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CHILDREN OF ALCOHOL AND DRUG ABUSERS

HEARING

BEFORE THE

SUBCOMMITTEE ON
CHILDREN, FAMILY, DRUGS AND ALCOHOLISM

OF THE

COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

FIRST SESSION

ON

EXAMINING ISSUES RELATING TO THE CHILDREN OF ALCOHOL AND DRUG ABUSERS

MAY 12, 1987

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CONTENTS

STATEMENTS

TUESDAY, MAY 12, 1987

Page

- Brooks, Cathleen, president, National Association for Children of Alcoholics, South Laguna, CA; Frank Rothgeb, assistant vice president for investments, Johnston, Lemon & Co., Washington, DC; and Beverly W. Jones, program manager for child protective services, Department of Human Resources, State of Maryland 142
  - Prepared statement of Ms. Jones 154
- Califano, Joseph H., Jr., honorary trustee, Children of Alcoholics Foundation; and Migs Woodside, president, Children of Alcoholics Foundation 7
  - Prepared statements of:
    - Mr. Califano 10
    - Ms. Woodside (with an attachment) 22
- Ladd, David, division chief, Child Protective Services, Anne Arundel County, MD 161
- Neal, James A., director, prevention, education and intervention, South Carolina Commission on Alcohol and Drug Abuse; Andrew Klein, chief probation officer, Quincy Division of the Trial Court of Massachusetts; Phil Diaz, director, Division of Alcohol and Drug Abuse, Rockland County Mental Health Center, Pomona, NY; and Ellen Morehouse, executive director, Student Assistance Services, White Plains, NY 95
  - Prepared statement of:
    - Mr. Neal 99
    - Mr. Klein 109
- Russell, Marcia, research scientist, Research Institute on Alcoholism, Buffalo, NY; E. Virginia Lapham, director of social work and associate professor, Department of Pediatrics, Georgetown University Hospital, Washington, DC; and Rosemary Tisch, president, Kids Are Special, San Jose, CA 48
  - Prepared statements of:
    - Ms. Russell 51
    - Ms. Lapham 66
- Thurmond, Hon. Strom, a U.S. Senator from the State of South Carolina, prepared statement 5

ADDITIONAL MATERIAL

Articles, publications, etc.:

- Children of Alcoholics in the Juvenile Justice System, from Readers Exchange, by Patricia O'Gorman, Ph.D., and Robert A. Ross 123
- Hispanic Alcoholics' Children Need Extra Help, from Reader's Exchange, by Ronaldo L. Figueroa, M.A., C.A.C., and Philip Oliver-Diaz, M.S.W. 126
- Books for Young Children of Alcoholics and Other Children of Tuma, by Patricia O'Gorman and Philip Oliver-Diaz 128
- National Association for Children of Alcoholics, resolution 146

CHILDREN OF ALCOHOL AND DRUG ABUSERS

TUESDAY, MAY 12, 1987

U.S. SENATE,
SUBCOMMITTEE ON CHILDREN, FAMILY,
DRUGS AND ALCOHOLISM,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The Subcommittee met, pursuant to notice, at 9:37 a.m., in Room SD-430, Dirksen Senate Office Building, Senator Christopher J. Dodd (Chairman of the Subcommittee) presiding.

Present: Senators Dodd and Thurmond.

OPENING STATEMENT OF SENATOR DODD

Senator DODD. The Subcommittee on Children, Family, Drugs and Alcoholism will come to order.

This morning, I am pleased to announce that this particular hearing will be the first of a series of educational forums designed to educate my colleagues here in the Senate and the public at-large about the issues of critical importance to children and families across this Nation.

In this series, we will not be looking at any particular piece of legislation, nor will I be necessarily proposing any legislation. I know that comes as somewhat of a surprise. Normally, the hearings are about a bill or about a law, a proposed law, but I happen to feel very strongly that a not often used role that we in the Congress can take advantage of is the notion of just trying to educate people, allow people to learn about a problem. In many instances just being aware of a problem will begin to ameliorate it because people start doing things on their own without having to put a law on the books.

Thus these sets of hearings will be fundamentally educational. This I might point out was the strategy that Senator Arlen Specter, and I used for 4 years as the founders of the Children's Caucus in the Senate. We held a series of hearings over 4 years on particular problems affecting children—latchkey children, gifted and talented, dropouts, abused children and the like.

We did not have any laws in mind particularly at those times, but we felt the need to inform people about the growing problems in those areas. We also learned, of course, that raising public awareness can be more than just half of the battle.

At any rate, this morning I hope that my distinguished colleague, Senator Thurmond, who agrees with this particular format, will be able to join us. He feels very strongly, I might add, about this particular issue.

Today, we are going to address specifically a most alarming problem; namely, the risks to children posed by parental alcohol and drug abuse. We know that such risks can be both numerous and very serious, starting before birth and following children well into adulthood. We also know that children growing up in homes where there is alcohol and drug abuse face a far greater risk of becoming alcohol and drug abusers themselves.

Until recently, the children of alcohol and drug abusers have been overlooked in our homes, schools and communities. Treatment programs for parents abusing substances have not traditionally included the children affected at home. This is the first such hearing that I know of ever held in the Congress that focuses on the children of alcoholics and drug abusers. And given that only 10 to 15 percent of the adults in this country who suffer from alcoholism receive any form of treatment, the overwhelming majority of children of alcohol and drug abusers will continue to be ignored unless special programs are put into place for them. It is important to note that this, as I mentioned, is the first congressional hearing to focus on these particular children. Previous hearings have focused almost exclusively on adult abusers.

As we will hear from our distinguished witnesses this morning, an estimated 7 million children under the age of 18 now live in families where at least one parent abuses alcohol, and some 20 million American adults share the experience of having grown up in an alcoholic family.

By the way, that 7 million children may not seem like a large figure, if you think of a Nation of 240 million; but if you think of the fact that there are 60 million children in the country, 7 million is a significant percentage of the child population of this country.

Much less, of course, is known about children growing up in homes where parents abuse drugs. We have not yet developed the statistics in that area. According to the National Institute on Drug Abuse, we have no nationwide statistics on studies of infants born with drug withdrawal problems. Recent scattered reports, however, suggest their numbers are rapidly increasing. In one public hospital in Fort Lauderdale, Florida, last year, one out of every five infants was born with drug related problems—one out of every five children in that hospital. And in New York City, the number of babies experiencing alcohol and drug withdrawal problems increased 85 percent between March 1986 and 1987, according to Child Protective Services in that city.

We know that infants born to parents who abused alcohol and drugs during conception and pregnancy are more likely to be low birth weight, hyperactive babies with significant feeding and sleeping problems. Those who survive the first year of life are more likely to have permanent physical or mental handicaps than other infants. The fetal alcohol syndrome [FAS], which is triggered by maternal alcoholism during pregnancy, for example, is the third leading cause of birth related mental retardation in this country. Less severe fetal alcohol effects can also result in low birth weight and developmental delays during infancy, increasing the risk of significant disability. Studies indicate that such infants may continue to lag behind their peers in physical and cognitive development throughout their preschool years.

It is important to note here that the National Council on Alcoholism is launching a campaign this week to increase public awareness of the problem of fetal alcohol syndrome. Although I was pleased to join my colleague from Utah in sponsoring a bill to designate this week as National Fetal Alcohol Syndrome Awareness Week, unfortunately the House of Representatives was unable to complete action in time to effect this legislation. We will try again next year to establish that week of recognition.

Children of alcohol and drug abusers who escape birth defects may encounter other serious problems as they are growing up. So you have the infancy problem and then there are problems with teenagers. Many are at risk of physical and sexual abuse or neglect.

In my home State of Connecticut, one out of every five children identified by the Children Protective Service System 3 years ago had a parent who was a substance abuser. Today, that number has jumped to one out of every four children in the State of Connecticut.

Children of alcohol and drug abusers are more likely to experience significant emotional problems during adolescence and on into adulthood. Some children from alcoholic homes do poorly in school, attending less regularly and concentrating less in classes, thereby greatly increasing the risk of dropping out. Others may act out and fall prey to delinquency.

Even by conservative estimates, every other young person who becomes enmeshed in the juvenile justice system in this country comes from an alcoholic home. Sometimes we run over these statistics, but I was going over the data myself and that statistic just leaped off the page. I think it's important not to skim over the fact that every other young person in the juvenile system in this country is a child coming from an alcoholic home. There are some experts in the country who will tell you that they believe that that number actually hovers closer to 80 percent.

At any rate, vastly over-representative in such statistics are minority youth. However, the vast majority of young Americans running away from home are the children of alcohol and drug abusers as well. Given that an estimated 1.25 million children are runaways or homeless every year, the numbers of children driven from their homes by alcohol and drug abuse are substantial indeed.

Last but not least, these young people are at great risk of abusing drugs and alcohol themselves. Children of alcoholics are four to five times more likely to become alcoholics than other children. And those who do not end up abusing substances have a greater risk of marrying a substance abuser. The long-term costs of perpetuating a cycle of intergenerational alcohol and drug abuse are tragic in both human and obviously fiscal terms. As we will hear from experts this morning, the health care and lost productivity costs of alcohol abuse totals, according to some, about $130 billion a year.

Not all the children of alcohol and drug abusers do poorly. Some become very high achievers, doing well at school and also managing to take care of their siblings and parents at home. Although some of these children become so-called overachievers, leaving them at risk for emotional problems and job burnout later in life, others do not. We need to know more about why some children from alcoholic homes seem to do better than others.

In closing this morning, last year I sponsored a piece of the Omnibus Drug Reform Act that received so much attention it set up model alcohol and drug abuse prevention and treatment programs for high-risk youth. By the nature of the problem, high-risk youth automatically include those who are the children of alcohol and drug abusers.

Our distinguished witnesses this morning will lay out the risk factors and describe appropriate prevention and treatment methods, and it is the hope of this Member of the Senate that our hearing today will help increase awareness of the negative effects of parental alcoholism and drug abuse of children.

Lastly this hearing should help the 28 million Americans who are the past and present children of alcohol and drug abusers recognize that they are not alone in this particular struggle.

So again this morning, I want to thank our witnesses for being here and for sharing with us their thoughts and comments on how we might increase public awareness, and even some ideas on the legislative front.

I would just add in closing that, given the very strong evidence that parental alcohol and drug abuse can significantly affect health and welfare, education and future development of children, I am sending letters this morning to Secretary Bowen of the Department of Health and Human Services, Secretary Bennett of the Department of Education, and Attorney General Edwin Meese, asking them to report to the Subcommittee in 90 days on their efforts to gather national data and structure programs to help meet the special needs of the children of alcohol and drug abusers. In that way we might begin, at least, to trigger some response from this administration or the next as we look down the road. If we begin to collect the data and to require the government to focus on it, I think we might find some better legislative answers.

Before we proceed with the first witness, we will include in the record a statement by Senator Thurmond.

[The prepared statement of Senator Thurmond follows:]

STATEMENT BY SENATOR STROM THURMOND (R.-S.C.) BEFORE THE SENATE SUBCOMMITTEE ON CHILDREN REFERENCE HEARING ON CHILDREN OF ALCOHOL AND DRUG ABUSERS. TUESDAY, MAY 12, 1987, SD-430, 9:30 AM.

MR. CHAIRMAN:

There are 28 million children of alcoholics in the United States. 7 million are under the age of 18. One out of every eight Americans is the child of an alcoholic.

The effect of this on children is devastating. They often feel guilty or responsible for parental drinking or drug abuse. This in turn can create long-term problems in adjusting to society as they reach adulthood.

Mr. Chairman, I recently viewed an exhibit of drawings by children of alcoholics sponsored by the Foundation on Children of Alcoholics. I had the pleasure of having Miggs Woodside, the founder of this organization and one of our witnesses today, show me this exhibit. From these drawings, it was clear and saddening how devasting alcohol and drugs abuse can impact a family.

Ms. Woodside, we are glad to have you here today and look forward to hearing your testimony.

Mr. Chairman, I am also pleased to welcome Jim Neal, Director of Prevention, Education and Intervention of the South Carolina Commission on Alcohol and Drug Abuse. Mr. Neal has been very involved in developing a state-wide student assistance program for students in our schools having problems with drugs and alcohol. I understand that last week the National Association of Student Assistance Programs recognized the program in South Carolina as the most outstanding in the Nation, and I commend them for this fine achievement.

Mr. Neal, we are very pleased to have you here today, and I am confident that the Committee will benefit from what you have to say.

Mr. Chairman, I also wish to commend you for conducting this hearing on this serious problem. This Committee can accomplish a great service just by educating people. These hearings provide an excellent opportunity to do just that. We do not always have to have a particular piece of legislation as a subject of a hearing to raise public awareness. I commend the Chairman for recognizing how valuable a Committee hearing can be to educate the people.

Mr. Chairman, while my schedule may not permit me to stay for the entire hearing, I look forward to reviewing the testimony of the witnesses today.

Senator Dodd. We are thrilled this morning to have as our very first witness a good personal friend, also one of the recognized experts in this country on health related matters, the former Secretary of the Department of Health, Education, and Welfare, now the Health and Human Services agency. He hardly needs much more of an introduction than that, he is one of the most recognizable figures in this country on matters such as this. He has done a tremendous job, in being highly supportive of the efforts in dealing with the children of alcohol or substance abusers.

Joe Califano, we welcome you here this morning and we are delighted to have you with us.

STATEMENTS OF JOSEPH A. CALIFANO, JR., HONORARY TRUSTEE, CHILDREN OF ALCOHOLICS FOUNDATION; AND MIGS WOODSIDE, PRESIDENT, CHILDREN OF ALCOHOLICS FOUNDATION

Mr. Califano. Thank you, Mr. Chairman. It is a privilege to be here and to have an opportunity to testify at these hearings, the first ever in the United States Congress on children of alcoholics. I think you are certainly to be congratulated for your own dedication and commitment to these children and to this problem.

Addiction is America's number one health problem, and alcoholism and alcohol abuse are still the largest aspect of that problem.

The costs of alcohol abuse to our society, including health care and lost productivity, will approach, as you indicated, $135 billion this year. Of all the major diseases, only heart attacks and strokes come close to alcohol abuse in cost, and a significant portion of heart disease is caused by such abuse.

Millions of lives are affected: not only the 10 million alcoholics and problem drinkers, but their families and loved ones as well, including an estimated 7 million children of alcoholics under the age of 18, and another 21 million who have reached adulthood.

Although we can document the terrible financial toll of alcoholism, we still have much to learn about the disease itself. But we do know two things for sure: prevention is the most effective cure, and the earlier alcohol abuse is detected—or drug abuse, for that matter—the greater the likelihood of arresting the disease. Nowhere is prevention more important than with respect to children of alcoholics.

Research suggests an inherited predisposition for the disease of alcoholism. Sons of alcoholics are at four times greater risk of alcoholism than others, and grandsons of alcoholics are at three times greater risk. Daughters of alcoholic mothers are three times more likely to become alcoholics and are more likely than others to marry alcoholics.

Far more research is needed to explore the genetic, biomedical, psychological and social factors at work in the transmission of family alcoholism. But much can be done right now, through education, identification and early intervention, to break the cycle of family alcoholism.

Many alcoholics gain control of their disease and alcohol rehabilitation programs can be very cost-effective. Often, however, this occurs only after great psychic and physical damage has been done, both to the alcoholic and his or her family. A great deal of anguish can be avoided if we can identify and reach those at greatest risk for future alcoholism before they become victims of this dreadful disease.

Parental alcohol abuse can cause injury and harm to youngsters throughout their entire lives, from infancy through adulthood. Children of alcoholics are not only more likely to become alcoholics themselves, they are much more likely to develop a variety of physical, mental and emotional health problems.

The Fetal Alcohol Syndrome, which results from maternal alcohol abuse, can cause central nervous system abnormalities, mental retardation, microcephaly, and hypotonia as well as other abnormalities.

The infant years of children of alcoholics are often scarred and they tend to be subject to feeding problems, vomiting, and incessant crying. In childhood, they are more likely to complain of abdominal pain, headaches, difficulty in sleeping problems, tics and nausea, although no physical causes for such complaints may be found. Children of alcoholics are more prone to migraine headaches and asthma as physical responses to the anxiety, worry, fear, anger and guilt experienced as a result of living with an alcoholic parent.

Children of alcoholics account for an estimated 60 percent of young people entering our juvenile justice system. They are more frequently victims of child abuse. For example, a study of delinquent adolescents found that 55 percent of those who were abused had alcoholic fathers.

Other reports show that children of alcoholics are more likely to drop out of or be expelled from school, often for abusing alcohol and other drugs.

Some children of alcoholics, as you noted, Mr. Chairman, do very well and we need to learn more about why. As adults, children of alcoholics may suffer the physical and emotional consequences of living with an alcoholic family, daughters of alcoholics can use gynecological and obstetric services more often than other women, and sons of alcoholics use surgical and psychiatric facilities more frequently than other men.

Some children of alcoholics may in fact appear to cope well in childhood, but often, in mid-life, they may have problems stemming from life with an alcoholic parent.

Despite the demonstrated vulnerability of children of alcoholics, to date there are no curriculum materials for educating medical students, physicians and others in the medical community about the physical and mental health problems of children of alcoholics. Less than one percent of medical school class hours are devoted to the disease of alcoholism, which is one of our country's top diseases.

While some medical school curricula do address Fetal Alcohol Syndrome, there is no material available that addresses the full range of parental alcoholism's effects on children. As a result, many physicians and other health professionals who come in contact with children of alcoholics have been unable to identify and assist them in appropriate ways. Indeed, most are not even trained to spot and help patients cope with alcohol abuse.

Other witnesses here today will give you more details about the state of research on children of alcoholics, their needs for services and the availability of services.

What can be done to address the problems created by parental alcoholism.

First, we need the facts, Mr. Chairman, and your letters to those Cabinet officers is a terrific first step in putting our hands on those facts and getting their attention focused on this problem.

We also could use a major national study of familial alcoholism that looks at all the variables, including genetics, biology, chemistry, physiology, psychiatry and personality, psychosocial factors and the process of the disease over many years. The results of such an undertaking could yield critically needed answers and would have an important effect on future prevention, intervention and treatment efforts.

We need a long-term evaluation to determine what efforts are effective at reducing alcoholism and other problems among children of alcoholics.

We should require that alcoholism treatment programs funded under the ADAMHA block grant provide prevention and treatment services to the children of their clients.

We need a national public information campaign to alert children of alcoholics and their families and friends to the risks they face.

We need alcohol education programs in every grade and every school in this Nation that include components that focus on the disease of alcoholism as it affects family members, particularly children.

It is time to make children of alcoholics a priority on the Nation's health care agenda. At a time of tight budgets, we should focus our funds and resources on the targets that need the most help and provide the promise of the greatest savings in the future. Programs directed at children of alcoholics meet this standard.

Mr. Chairman, I just want to thank you again and congratulate you on holding these hearings. I think it is an extraordinary and very important first step.

Thank you.

[The prepared statement of Mr. Califano follows:]

STATEMENT OF JOSEPH A. CALIFANO, JR.*
BEFORE THE
SUBCOMMITTEE ON CHILDREN, FAMILY, DRUGS AND ALCOHOLISM
COMMITTEE ON LABOR AND HUMAN RESOURCES
U.S. SENATE

May 12, 1987

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* Mr. Califano, an Honorary Trustee of the Children of Alcholics Foundation, was Secretary of Health, Education and Welfare from 1977 to 1979, and President Lyndon Johnson's assistant for domestic affairs from 1965 to 1969. He is presently senior partner in the Washington Office of the law firm of Dewey, Ballantine, Bushby, Palmer & Wood, and chairman of the health care committees of Chrysler Corporation and American Can Company. His most recent book America's Health Care Revolution: Who Lives? Who Dies? Who Pays?, was published by Random House in 1986.

Mr. Chairman and Members of the Committee:

I appreciate the opportunity to testify today and congratulate you on these first-ever hearings -- the first ever in the U.S. Congress on children of alcoholics.

Addiction is America's Number One health problem. Despite the recent upsurge of concern over crack and cocaine, alcoholism and alcohol abuse are still the largest aspect of that problem.

The costs of alcohol abuse to our society, including health care and lost productivity, will approach $135 billion this year. The cost of drug abuse will be about half of that. Of all the major diseases, only heart attacks and strokes come close to alcohol abuse in cost -- and a significant portion of heart disease is caused by alcohol abuse.

And millions of lives are affected: not only the 10 million alcoholics and problem drinkers, but their families and loved ones as well, including an estimated 7 million children of alcoholics under the age of 18, and another 21 million who have reached adulthood.

Although we can document the terrible financial toll of alcoholism, we still have much to learn about the disease itself. But we know two things for sure: prevention is the most effective cure, and the earlier alcohol abuse is detected, the greater the likelihood of arresting the disease. Nowhere is prevention more important than with respect to children of alcoholics.

Research suggests an inherited predisposition for the disease of alcoholism. Sons of alcoholics are at four times greater risk of alcoholism than others and grandsons of alcoholics are at three times greater risk. Daughters of alcoholic mothers are three times more likely to become alcoholics and are more likely than others to marry alcoholics.

Far more research is needed to explore the genetic, biomedical, psychological and social factors at work in the transmission of family alcoholism. But much can be done right now, through education, identification and early intervention to break the cycle of family alcoholism.

Many alcoholics gain control of their disease and alcohol rehabilitation programs can be very cost-effective. Often, however, this occurs only after great psychic and physical damage has been done, both to the alcoholic and his or her family. A great deal of anguish can be avoided if we can identify and reach those at greatest risk for future alcoholism before they become victims of this dreadful disease.

Parental alcohol abuse can cause injury and harm to youngsters throughout their entire lives, from infancy through adulthood. Children of alcoholics are not only more likely to become alcoholics themselves; they are much more likely to develop a variety of physical, mental and emotional health problems.

The Fetal Alcohol Syndrome, which results from maternal alcohol abuse, can cause central nervous system abnormalities, mental retardation, microcephaly, and hypotonia as well as other abnormalities.

The infant years of children of alcoholics are often scarred by and tend to be subject to feeding problems, vomiting, and incessant crying. In childhood they are more likely to complain of abdominal pain, headaches, difficulty in sleeping problems, tics and nausea, although no physical causes for such complaints may be found. Children of alcoholics are more prone to migraine headaches and asthma as physical responses to the anxiety, worry, fear, anger and guilt experienced as a result of living with an alcoholic parent.

Children of alcoholics account for an estimated up to 60 percent of young people entering our juvenile justice system. For example, more than half of the young men incarcerated at a 232 bed residential facility in Canaan, New York, came from homes with an alcoholic parent.

Children of alcoholics are frequently victims of child abuse:

- A study of delinquent adolescents found that 55 percent of those who were abused had alcoholic fathers.
- A Massachusetts court investigating child abuse cases found that 42 percent of the child-

abusing mothers and 34 percent of the child-abusing fathers were alcohol or drug dependent.

Other reports show that children of alcoholics are more likely to drop out or be expelled from school, often for abusing alcohol and other drugs.

It is important to note, however, that some children of alcoholics actually do very well, and we need to learn more about how and why this happens.

Children of alcoholics may also suffer the physical and emotional consequences of living with an alcoholic family as adults. Daughters of alcoholics use gynecological and obstetric services more often than other women and sons of alcoholics use surgical and psychiatric facilities more frequently than other men. Adult sons of alcoholic parents show higher test scores for depression, introversion and schizophrenia. Recent research on adult daughters of alcoholics suggests a relationship between parental alcoholism and bulimia.

Some children of alcoholics may in fact appear to cope well in childhood, but often, in mid-life, they may have problems stemming from life with an alcoholic parent. In particular, those youngsters who were "super-copers" and took responsibility for the family by caring for others, cooking meals, running the household and even balancing the family checkbook, may later become super-over achieving executives, more prone to serious problems in the workplace.

Despite the demonstrated vulnerability of children of alcoholics, to date there are no curriculum materials for educating medical students, physicians and others in the medical community about the physical and mental health problems of children of alcoholics. Less than one percent of medical school class hours are devoted to the disease of alcoholism. While some medical school curricula do address Fetal Alcohol Syndrome, there is no material available that addresses the full range of parental alcoholism's effects on children. As a result, many physicians and other health professionals who come in contact with children of alcoholics have been unable to identify and assist them in appropriate ways. Indeed, most are not even trained to spot and help patients cope with alcohol abuse.

Other witnesses here today will give you more details about the state of research on children of alcoholics, their needs for services and the availability of services.

What can be done to address the problems created by parental alcoholism? Here are a few suggestions for government action.

- First, we need a major national study of familial alcoholism that looks at all the variables, including genetics, biology, chemistry, physiology, psychiatry and personality; psychosocial factors and the process of the disease over many years. The results of such an undertaking could yield critically needed answers and would have an important effect on future prevention, intervention and treatment efforts.

- We need a long-term evaluation to determine what efforts are effective at reducing alcoholism and other problems among children of alcoholics.
- We should require that alcoholism treatment programs funded under the ADAMHA block grant provide prevention and treatment services to the children of their clients.
- We need a national public information campaign to alert children of alcoholics and their families and friends to the risks they face and the availability of help.
- We need alcohol education programs in every grade and every school in this nation that include components that focus on the disease of alcoholism as it affects family members, particularly children.

It's time to make children of alcoholics a priority on the nation's health care agenda. At a time of tight budgets we should focus our funds and resources on the targets that need the most help and provide the promise of the greatest savings in the future. Programs directed at children of alcoholics meet this tough standard. If we take these steps -- expand basic research, extend current alcoholism treatment programs to include families, evaluate programs, get prevention programs in the schools, and mount an effective public information campaign -- we can reduce the pain and suffering in the lives of millions and save our health care system literally billions of dollars in the future.

Mr. Chairman, I again congratulate you and your committee for holding these hearings.

Senator **Dodd**. I thank you for that.

You have sitting at your left, of course, an in[illegible]at is in no small way responsible for the fact that we are all here. Migs Woodside has been involved for a number of years. I do not want to say how many, Migs, but it goes back to Birch Bayh, and just for purposes of connections there was a subcommittee of the Judiciary Committee called the Juvenile Delinquency Subcommittee, and my father chaired that committee for a number of years. When he gave it up, Birch Bayh became interested, and some of the first hearings relating to the subject of children, came out of that Juvenile Delinquency Subcommittee. Birch Bayh picked up on it and did a tremendous job. Of course, he was involved in the Constitution Subcommittee as well, where I know you became involved with it.

Anyway, you founded the Children of Alcoholics Foundation in 1982 as a result of studies which you conducted. For those of you in the audience and the press, the art work exhibited behind me today is not the extent of it. There are many more pieces in New York. But I hope you get a chance to take a look at the few drawings we have here at the conclusion of these hearings. This is artwork done by the children of alcoholics and some of it is just appalling. It is a message far more eloquent, with all due respect, than all the testimony you will hear today. Statements expressed by a five-year-old or a six-year-old or a seven-year-old in the simple coloring and a few phrases.

By the way, there have been some excellent programs done on this issues. One was done by a San Francisco reporter on a camp outside of San Francisco where children of alcoholics go for a few days. To listen to the interviews of these children talk about what it is like to grow up in an alcoholic home is quite an eye-opener. The children at the camp have parents in recovery. They know their alcoholism has created problems and they want their children to learn how to cope as the parents try to wrestle with their recovery. If we could just get that film a wider circulation and get more people to focus on the problem, then I think we could make great strides forward.

At any rate, the artwork here is very much a part of that effort. It is going to be going around the country. Private corporations and businesses have promised to see to it that it gets an adequate and good showing so that people can be aware of this problem.

I might also add that Migs is from my home State of Connecticut, Litchfield. Her husband, Bill, is here this morning as well and we really thank you, all of us do. If it were not for you, I do not believe we would be holding the hearing today and we would not be focusing as much attention on a problem that really deserves a lot more than it receives.

So we are delighted to welcome you here this morning and we will receive your testimony any way you want to give it, Migs. It will be included in the record.

Ms. **Woodside**. Thank you. Thank you, Mr. Chairman. You are more than generous in your remarks. I appreciate it.

It is really an honor to appear before you today to discuss the problems and needs of the Nation's 28 million children of alcoholics. The Children of Alcoholics Foundation believes there is a pressing need to make the American public and its leaders aware of the intergenerational links in the disease of alcoholism, to reduce the suffering and pain of those from alcoholic families and to prevent future alcoholism. We hope this hearing will be a major step forward in increasing awareness and will set the stage for improving the Nation's response to the many problems which result from parental alcohol abuse.

The Children of Alcoholics Foundation was established in 1982 as a voluntary nonprofit, public organization to assist children of alcoholic parents. And as you mentioned before, my own involvement and commitment to this important issue began earlier, and I will tell the truth, it was 1980.

I was then a consultant to the Senate Judiciary's Subcommittee on the Constitution. At that time, the Juvenile Justice and Delinquency Prevention Act of 1974 was coming up for reauthorization and included in that major Act was Title III, the Runaway and Homeless Youth Act.

Now, we had already learned that there were children in this country living in alleys and on rooftops, and in garages, surviving by begging, stealing and even prostituting themselves to stay alive, and we wanted to make services available to help these youngsters who could not go home. To demonstrate this need and in support of the legislation, I wrote a report, titled "Homeless Youth: The Saga of Pushouts and Throwaways in America." And what we found out, the major reason that youngsters could not go home was because of parental alcohol abuse.

The following year, Joseph A. Califano, in his role as Special Counsellor on Alcohol and Drug Abuse to Governor Hugh L. Carey, of New York, asked me to prepare a comprehensive study of children of alcoholics as part of his larger report to the Governor on alcohol and drug abuse problems.

The release of the study generated both national and international interest, subsequently reinforced by the Nation's first and only Governors Conference on Children of Alcoholics, held in October 1982 in New York. And I will tell you that the response from both the public and the media was absolutely astonishing. We received thousands of phone calls and letters from all over the United States and even as far as Western Europe from people asking for information, how could they get help for themselves and for their children. In addition, people also began to send contributions, and at that point the Children of Alcoholics Foundation was formed.

Considering the numbers, 28 million children from alcoholic families, perhaps we should not have been so surprised and, as you probably know from your own experience with friends, colleagues and associates, alcoholism seems to run in families. While no specific gene or DNA has been identified for alcoholism as there has been for blue eyes or for blonde hair, it is likely one can inherit a predisposition. And as both you and Mr. Califano indicated, children of alcoholics are four times more likely to become alcoholics than others.

As you both also indicated, not all children of alcoholics grow up and become alcoholic. Some in fact may do very well and appear to cope and to succeed. However, in general, children of alcoholics have more physical, emotional and mental health problems than others as a result of their experience in an alcoholic family.

Now, you may wonder what is so special about these youngsters as opposed to others from problem families. Well, there are some special things. First of all—and this is a real tragedy—children do not know that alcoholism is a disease which they cannot cause, control, nor cure. In fact, they truly believe that if they were better behaved in school, picked up their clothes, got along better with their siblings, their parents would stop drinking. Of course, the parents reinforce this by saying you are driving me to drink, and children believe it. They growing up feeling guilty and responsible for their parents 'alcohol abuse.

They also feel rejected and unloved because the entire household revolves around the alcoholic parent. The child is always second best and never as important as the alcoholic. There is a great deal of fighting and tension and rules change from minute to minute, according to the level of alcohol in the parent's bloodstream. This means that youngsters never know what to expect. When is the right moment to ask for money for new sneakers or to get a report card signed? They never know. The simplest requests for help can turn into major explosions.

Also, they are very isolated, they are afraid to bring friends home, afraid their parent will be drunk or ill, lying on the floor, which is far too mortifying to let anybody else know about and, even worse, alcoholism is a family secret and youngsters dare not betray their family by talking about what is happening at home and asking for help. They are told, "When grandma comes for Mothers Day, don't tell her dad is drinking again." They keep their pain and suffering locked inside.

As you mentioned, the experience of children of alcoholics is graphically represented in the selection of artwork we brought here today. These pictures are taken from the Foundation's national exhibit of over 500 pictures, stories, letters and poems by children of alcoholics and, as you know, because you visited it, it was shown in the Rotunda of the Cannon Office Building in March, where it was cosponsored by our Honorary Advisor, the Honorable Charles B. Rangel, and our dear distinguished friend, the Honorable Late Stewart B. McKinney.

This exhibit reflects a portrayal of the pain, loneliness and despair caused by parental alcohol abuse throughout this country, regardless of any geographic, ethnic, or social economic differences, and our plan now is to turn this into an alcohol education and prevention program for effective use in our Nation's schools for all children to see.

The pictures, some of them here, show suicide, family violence, accidents, child abuse, neglect, anger, fear, and many of the other problems which you raised so eloquently in your opening statement.

I do want to say that at the Children of Alcoholics Foundation we believe children from alcoholic families are worthy and deserve help for themselves. This is our message and the basis of our work for both youngsters and adults. We also believe it is unnecessary to start new bureaucracies and new systems to deal with children from alcoholic families.

Considering their numbers, we know they can be found in all kinds of programs and organizations. What we do need to do is to educate professionals and let them know simple, cost free, easy but effective ways they can help this huge and greatly neglected vulnerable population.

[The prepared statement of Ms. Woodside, with an attachment, follows:]

STATEMENT OF MIGS WOODSIDE

PRESIDENT,

CHILDREN OF ALCOHOLICS FOUNDATION, INC.

BEFORE THE

SUBCOMMITTEE ON CHILDREN, FAMILY,

DRUGS AND ALCOHOLISM

U.S. SENATE

May 12, 1987

Mr. Chairman and Members of the Committee:

It is an honor to appear before you today to discuss the problems and needs of children of alcoholics. The Children of Alcoholics Foundation believes there is a pressing need to make the American public and its leaders aware of the intergenerational links in the disease of alcoholism, to reduce the suffering and pain of those from alcoholic families and to prevent future alcoholism. We hope this Hearing will be a major step forward in increasing awareness and will set the stage for improving the nation's response to the many problems which result from parental alcohol abuse.

The Children of Alcoholics Foundation was established in 1982 as a voluntary, non-profit, public organization to assist children of alcoholic parents. The major goals of the Foundation are to inform and educate the general public and professionals about children of alcoholics; to promote and disseminate research and new data on family alcoholism and its effect on children; to assess the effectiveness of public programs, policies and laws; to encourage Federal, state and local community based agencies to respond to the needs of children of alcoholics; and to help break the intergenerational cycle of family alcoholism through its own educational programs.

My own involvement and commitment to this issue began back in 1980 when I was a consultant to the Senate Judiciary's Subcommittee on the Constitution, chaired by

Senator Birch Bayh. Of course, Senator Thurmond was also a member of that distinguished Committee. At that time, the Juvenile Justice and Delinquency Prevention Act of 1974 was coming up for reauthorization and included in that major Act was Title III, the Runaway and Homeless Youth Act. We had already learned that there were children in this country living in alleys and on rooftops, and in garages, surviving by begging, stealing and even prostituting themselves to stay alive, and we wanted to make services available to help these youngsters. To demonstrate their need, and in support of the legislation, I wrote a report, titled "Homeless Youth: The Saga of Pushouts and Throwaways in America."

To do this, I interviewed 21 programs across the country for runaways, other service providers, and youngsters who did not even know where they would sleep that night. One thing fast became clear. Both programs and youngsters concurred a major deterrent to their ability to go home again was the fact of parental alcohol abuse. In fact, the majority of programs reported that between 30 and 60 percent of their homeless youth populations came from families with alcohol problems. As one youth shelter reported, the complaint heard most often is "my parents drink -- I can't take it anymore."

What I did not know at the time was that, in addition to the physical, emotional and mental health problems caused by parental alcohol abuse, there is an inherited predisposition to alcoholism and that homeless youth, and other children from alcoholic families, were statistically at much greater risk than others to become alcoholic in the future.

The following year I was asked by Joseph A. Califano, Jr., in his role as Special Counsellor on Alcohol and Drug Abuse to Governor Hugh L. Carey of New York, to prepare a comprehensive study of children of alcoholics as part of a larger report to the Governor on alcohol and drug problems.

As I reviewed the research, talked with staff of programs serving children of alcoholics and met with youngsters from alcoholic families, I was deeply impressed with the dimension of the problem and the lack of response compared to the widespread need. The release of that study, Children of Alcoholics, generated both national and international interest, subsequently reinforced by the nation's first and only Governor's Conference on Children of Alcoholics held in October, 1982 in New York. The response from the public to media stories on both the study and this conference was extraordinarily enthusiastic and, to us, unexpected in its degree of intensity. We were overwhelmed by phone calls and with letters requesting information and help from all over the United States and even Western Europe. And just as surprising, people even began to send us checks. To respond to this tremendous outpouring of public interest, the Children of Alcoholics Foundation was formed.

As you probably know from your own experience with friends, colleagues, associates and even relatives, alcoholism seems to run in families. While no specific gene or DNA has been identified for alcoholism as there is for blue eyes or blonde hair, it is likely one can inherit a predisposition for alcoholism. In fact, we know that children of alcoholics are 4 times more likely to become alcoholics than others.

Now, not all children of alcoholics grow up and become alcoholic. Some, in fact, may do very well and appear to cope and to succeed. However, in general, children of alcoholics have more physical, emotional and mental health problems than others as a result of their experience in an alcoholic family.

You may ask what's so special about children of alcoholics as opposed to other youngsters who come from problem families. First of all, these children do not know that alcoholism is a disease, nor do they know it is a disease which they cannot cause, control, nor cure. In fact, they believe that if they were better behaved, picked up their clothes, did better in school, got along better with their siblings, their parent would stop drinking. Of course this isn't true, but to add to the problem, parents often blame youngsters and tell them their behavior drives them to drink. As a result, children of alcoholics feel guilty and responsible for their parent's alcohol abuse. They truly believe it is all their fault.

Too, children of alcoholics feel rejected and unloved because the entire household revolves around the alcoholic parent. The child is always second best, feels invisible and is never as important as the alcoholic. Also, there is a great deal of fighting and tension and rules change from minute to minute according to the level of alcohol in the parent's bloodstream. This means that youngsters never know what to expect. They never know when it is safe to ask for money to go on the school trip, or to have a report card signed, and the simplest requests for help can turn into explosions.

Children of alcoholics are also very isolated, they are often afraid to bring friends home, afraid that the parent will be drunk or ill, lying on the floor, which is far too mortifying to let friends see. To make matters even worse, alcoholism is a family secret and youngsters dare not betray their family by talking about what is happening at home and asking for help. They keep their pain and suffering locked inside.

The experience of children of alcoholics is graphically represented in the selection of artwork displayed here today. These pictures from the Foundation's national exhibit of over 500 pictures, stories, letters and poems by children of alcoholics reflect a portrayal of the pain, loneliness and despair caused by parental alcohol abuse throughout this country, regardless of any geographic, ethnic or socioeconomic differences.

The pictures show suicide, family violence, accidents, child abuse, neglect, anger, fear and loneliness. And there are other problems which result. As youngsters, children of alcoholics are more likely to have psychosomatic illnesses, few friends, or learning problems in schools. As teenagers, they are more likely than others to use alcohol or drugs, drop out of school, become truant or delinquent. Later on as adults, children of alcoholics are more likely to have problems in family relationships and difficulty at work.

However, not all children of alcoholics show these kinds of behaviors. In fact, some are super copiers, mini adults who take care of the entire family, clean the house, pay the bills, cook for everyone, even tell lies to protect mom or dad when they are absent from work and their office calls. Although these youngsters may appear to do extraordinarily well, they usually do not experience a true sense of self-satisfaction or worth in their youth or later on as adults.

In general, children of alcoholics do not get the help needed to prevent their own future alcoholism and alleviate their current pain and suffering. And there are reasons for this. First of all there is a myth that if a parent gets help and recovers, the child will also be fine. But that is not the case; the bizarre and difficult events the child has experienced may well carry over into adulthood and later life as permanent scars. And, in addition, only

10-15% of the country's alcoholics go into treatment and get help. This means that if we sat back and waited for the parent to recover, most children of alcoholics would continue to be overlooked. Too, treatment programs and agencies whose purpose is to help alcoholics focus primarily on adults. For the most part, they are not trained or equipped to deal with children's problems. And finally, there are limited resources available to treatment programs and while health insurance policies usually cover treatment for alcoholics, many do not cover services for the family. Further, we have found that even when children are included in family treatment, there is little attention paid them and they are usually brought in for only one or two sessions, if at all.

At the Children of Alcoholics Foundation, we believe that children of alcoholics are worthy and deserve help for themselves. This is our message and the basis of our work for both youngsters and adults from alcoholic families. We also believe it is unnecessary to start new bureaucracies and new systems to deal with children from alcoholic families. Considering their numbers, we know they can be found in all kinds of programs be it a mental health agency, court program, a youth club or in schools. What we do need to do is educate professionals in alcoholism agencies, child abuse agencies, health care services and schools, about children of alcoholics and let these professionals know simple, cost-free, easy, but effective ways they can help this huge and greatly neglected vulnerable population.

Within the last 3 years, there has been some growth in the number of very limited specialized services for children of alcoholics, although only a handful are reached. In general, these services have emerged as components of hospital treatment programs or of comprehensive community alcoholism agencies such as those sponsored by local councils on alcoholism. New, stand-alone programs have been created. And in a few areas, schools are beginning to provide prevention, counseling and referral programs.

Last year, the Children of Alcoholics Foundation developed an inventory of programs specifically designed to serve children of alcoholics. Through a national survey, we identified 235 programs in 34 states; 145 of these served children under 18. In general, we found:

- They are mostly new. About three-fourths had been in operation three years or less;
- They tend to be small: about half serve 50 or fewer children each year;
- They tend to be concentrated in a few states: primarily California, New York, Wisconsin and Massachusetts.

Another source of help for children of alcoholics are local Alateen groups. This is a particularly valuable resource because Alateen groups are one of the few places youngsters can be directed without prior knowledge or consent of their parents. Unfortunately, while the tremendous importance and need for Alateen is widely acknowledged, in many areas Alateen groups do not exist.

Even when they do exist, there are obstacles to participation by young people -- including lack of public transportation (especially for those under the driving age) and the usual need to keep participation a secret from the alcoholic parent.

Adults who have grown up in alcoholic families have achieved increased visibility and there are growing numbers of counseling, therapy and self-help programs for adults as well as a national membership organization individuals can join. Even so, as with young people, the established service delivery systems are generally not cognizant of or organized to respond to the needs of children of alcoholics. Employee assistance programs are one example.

Recent work by the Foundation with major corporations and EAPs found that the concept of "children of alcoholics" as a group in the workforce is relatively new. Most employers do not recognize that this population exists. Nor do they know that many of the nation's 21 million children from alcoholic families are likely to be among their colleagues, supervisors and co-workers.

Yet, a preliminary review conducted for the Children of Alcoholics Foundation of 100 randomly selected case records from a variety of employee assistance programs showed at least 28% of the cases were employed children of alcoholics. When other probable indicators of parental alcohol abuse were included, the figure rose to 35%.

A second survey for the Foundation of 500 randomly selected records of 54 companies across the United States found that children of alcoholics who contacted employee assistance programs were more likely than other employees seeking help to have low self-esteem, be overly responsible, be inflexible, have an excessive need for approval, and feel depressed.

However, we need to point out that children of alcoholics can also be great employees because they function very well in times of crisis. Coming from a childhood fraught with chaos, inconsistency and changed signals, they ingested crisis with their morning cereal. They also have strong instincts to step in, take over and proceed full speed ahead. When things on the job go wrong, often it is the children of alcoholics who come through and shine.

In addition, they can be very loyal, to their department, their supervisor and their colleagues. Just as they never told the family secret as youngsters, so they carry this characteristic into adulthood. Further, they may be very task oriented and, although they may have more difficulties with interpersonal skills than others, they can also be the functioners who get the job done.

The ultimate mission of the Children of Alcoholics Foundation is to see that children of alcoholics are prevented from becoming alcoholics, that they are spared the many serious problems which can result from growing up in an alcoholic family and that those already experiencing difficulties are encouraged to seek help and support.

Much can be done by concerned parties inside and outside of government to increase public and professional awareness of the vulnerabilities and needs of children of alcoholics and to provide help through prevention and intervention programs.

My recommendations fall into three categories: research, professional education and training, and prevention and intervention.

Research

- There is a need for a world-wide review of research on children of alcoholics followed by an international conference on alcoholism and the family that would bring together for the first time scientists working in this area to raise public awareness of this issue worldwide and promote cross-national investigations.
- The health care utilization and cost patterns of children of alcoholics need to be fully documented as no comprehensive study of this kind exists. Such data can demonstrate that it is not only humane to help children of alcoholics but that it is also in this nation's best financial interest to do so. A study of this nature can also help identify those points of access to our health care system where children of alcoholics are most likely to be encountered by medical personnel and point the way for effective prevention and intervention efforts.
- We need a major symposium or conference on resilient children of alcoholics. We need to find out how some seem to escape the problems encountered by other children of alcoholics. What are the protective barriers which keep them from becoming alcoholics? What can we

learn from their experience which can be used to help others?

- We need seed grants of financial support to attract new and promising researchers to study children of alcoholics. Only through building and supporting a cadre of dedicated researchers can we hope to find the answers to the problems of children of alcoholics.

Education and Training

- Alcohol treatment programs and child abuse workers tend to be poorly informed about each other's fields. Alcoholism counselors need to be more sensitive to the issues of family violence and abuse and neglect, and child abuse workers need to have better information about alcoholism and to understand their own reactions to the stigma and myths of the disease. It is urgent that alcoholism counselors and child protective workers be given sufficient training so that they can fully respond to the needs of the alcoholic family.

- Other professionals likely to come in contact with children of alcoholics need education and training in how to identify and appropriately respond to their needs. In particular, curriculum materials need to be developed and used in medical, nursing and other health professional schools and in continuing education programs. In addition, teachers, guidance counselors, social workers, clergy and others should receive instruction as part of their professional training in school and on the job.

Prevention and Intervention

- School-based alcohol education and prevention programs which focus on the problems of family alcoholism are needed, especially for the crucial fifth to eighth grade years. These programs should include information for teachers and students about ways youngsters can help their friends and should also stimulate children needing help to seek it.

- Employers, especially large corporations, can do much by making sure appropriate corporate personnel and EAP programs are knowledgeable and trained in these issues.

Finally, Mr. Chairman, I want to emphasize that, as individuals, each of us can help so much right in our own communities among the people we know. All of us can help a child living in a family with a drinking problem:

- We can be a good listener without pushing or questioning too hard. Be a friend who listens in an open, caring and accepting manner.
- We can invite a child to share a meal or social event or, if appropriate, to spend the night or weekend with our own families, particularly at holiday time when alcoholic families are unusually stressed.
- We can offer the child a quiet place to do homework in times of family fighting and violence.
- We can give the child a telephone number and offer to pick him/her up when a drinking parent drives.
- We can encourage children to think of someone else who would understand and help when help is needed ... a relative, neighbor, teacher or friend.
- We can encourage a child to become involved in enjoyable pastimes after school by recommending activity groups, teams, or clubs that might be appealing. Provide telephone numbers, or introduce the child to another member of the group.
- We can suggest a child use a school or community library to learn more about the disease of alcoholism.
- We can let a child know there are people trained to help such as counselors, alcohol information centers, councils on alcoholism and AlAnon/Alateen groups.
- We can help children understand that they do not cause their parents' alcoholism nor can they cure or control it. We can let them know

> they deserve help for themselves and that help is available for them.

Mr. Chairman, I want to congratulate this committee on its decision to hold this hearing. I would be happy to answer any questions you may have.

NATIONAL RESOURCES

Alcoholics Anonymous
P.O. Box 459, Grand Central Station
New York, NY 10163

Al-Anon Family Intergroup, Inc.
200 Park Avenue South
New York, NY 10003

Children of Alcoholics Foundation, Inc.
200 Park Avenue, 31st Floor
New York, NY 10166

National Association for Children of Alcoholics
31706 Coast Highway, Suite 201
South Laguna, CA 92677

National Council on Alcoholism
12 West 21 Street
New York, NY 10010

National Institute on Alcohol and Alcoholism Abuse
5600 Fishers Lane
Rockville, MD 20852

Children of Alcoholics Foundation, Inc.

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Children of Alcoholics Foundation, Inc.
200 Park Avenue, 31st Floor
New York, New York 10166
(212) 949-1404

CHILDREN OF ALCOHOLICS
FOUNDATION

CHILDREN OF ALCOHOLICS

FACTS

There are 28 million children of alcoholics in this country; 7 million of them are children under the age of 18. One out of every 8 Americans is the child of an alcoholic.

Alcoholism runs in families and children of alcoholics are at higher risk for their own alcoholism. Sons of alcoholic fathers are at 4 times greater risk of alcoholism than others. Daughters of alcoholic mothers are three times more likely to become future alcoholics than others, and more often marry alcoholic men.

Women alcoholics are twice as likely as men to have been reared by two alcoholic parents, and there is usually a higher rate of alcoholism in families of female alcoholics.

PROBLEMS

FOR YOUNG CHILDREN

Each year, 3,700 to 7,400 U.S. babies are born with Fetal Alcohol Syndrome (FAS) caused by maternal alcohol abuse resulting in growth deficiency, mental retardation, facial abnormalities and other birth defects. An additional 11,000 to 18,500 babies are born with fetal alcohol effects. (The annual cost to the nation of treating 68,000 FAS children under the age of 18 is $670 million, and the cost of treating 160,000 FAS adults annually is $760 million.)

As youngsters, children of alcoholics may have physical problems including headaches, tiredness and stomachaches, although no specific illnesses are detected. Also, they may have tics, nausea, enuresis, sleep problems, asthma and sensory problems with noise, bright lights, heat and cold more often than other children.

Young children of alcoholics may evidence such problems as emotional detachment, dependency, aggression, confusion of personal identity and lower self esteem.

Some young children from alcoholic families become exceedingly responsible and take on parental roles toward their siblings and others.

Teachers report that children of alcoholics are more likely to be hyperactive or delinquent. They have difficulty concentrating or forming trusting relationships.

FOR ADOLESCENTS

Teenage children of alcoholics are twice as likely to have psychiatric treatment for conduct disorders, anxiety or depressive symptoms or to abuse alcohol and other drugs.

Children of alcoholics are three times more likely to be expelled from school, or drop out due to early marriage, pregnancy, institutionalization, or military enlistment.

Some teenage children of alcoholics appear more resilient and are top-ranking "mini-adults" who perform all functions well, but seem to experience no personal satisfaction in their successes.

Recent studies indicate a relationship between bulimia and parental alcoholism.

Preliminary reports show a relationship between parental alcoholism and adolescent suicide, and that parents of those who attempt suicide use significantly more alcohol than other parents.

FOR ADULTS

Adult children of alcoholics use health services more frequently than others. Sons of alcoholics make more hospital visits, require more surgery and ambulatory care and make more visits to physicians for drug and alcohol abuse. Daughters of alcoholics make more visits to gynecological services.

Adult children of alcoholics may have more serious problems with anger and hostility and may experience more personal and social problems at younger ages including loss of employment due to alcoholism and arrests while drinking.

Adult children of alcoholics begin drinking and become alcoholic at early ages. They are more likely to experience greater enjoyment during early drinking occurrences which later result in an associated worsening of mood, tendency to get sick after intoxication and significantly more alcoholism symptoms.

Children of Alcoholics Foundation, Inc.
200 Park Avenue. 31st Floor
New York. New York 10166
(212) 949-1404

Senator DODD. Thank you very much for your testimony. I appreciate it immensely. Again, we thank you for the art exhibits here.

I will not keep both of you very long, just some general questions. I use the statistics, of 7 million children between the ages of 1 and 18, that are growing up in alcholic homes. We know that there are only about 10 to 15 percent of the adult population that gets treatment for alcoholism. How were we able to establish that number? If we know only a small percentage of the adults are getting treatment for alcoholism, is that number not a lot larger in the adult population? Are we able to determine that?

Do you know the answer to that, Joe?

Mr. CALIFANO. I think the number of 7 million children of alcoholics is a projection from the number of alcoholics estimated across the population.

Senator DODD. That may make some sense. Joe, you suggested childen should be educated at an early age about problems of alcholism. You have suggested there be programs in every grade to teach children how to cope with the difficulties of being in an alcholic home. Surgeon General Koop has been here and it seems like every time there is an issue that comes up—AIDS, sexual behavioir or drugs—there is another program to be incorporated in our school system. Everyone seems to agree there is not an age that seems too early to begin the educational process.

The question is: Are we overloading the system in educational efforts, or is there a better way in which to take all of these very legitimate issues and somehow combine them in a way so that they have some focus for children so they are not getting bombarded by messages that may dilute all of them?

Mr. CALIFANO. I think your point is well taken. I think we are really talking about health promotion and disease prevention, and I think they are all part of the threads of the same fabric. I think the children of alcoholics issue is a part of it, alcoholism is a part of it, tobacco is a part of it, AIDS is a part of it, drug abuse is a part of it. It is all part of the same health promotion program.

I think it belongs in the schools. I think you cannot start too young, because I think you can have a tremendous impact on the habits that children form and their attitudes toward alcohol and drug abuse, toward diets, toward everything else. I think everybody has got a part to play.

One of the things I think would be very important, if you just took those Saturday morning cartoon shows and ran some public service ads there about alcohol and drug abuse, for example, you would have a tremendous impact on those kids.

Senator DODD. It is interesting you mention that. In one of the hearings we held a few years ago, we learned the largest killers of kids is accidental, avoidable accidents. As chair of the Senate Childrens Caucus, I went to Children's Hospital to hold the hearing, and we had as our first panel of witnesses a bunch of kids who had various casts on for one thing or another. They were wonderful kids. I asked them how you reduce the chance of accidents. They all agreed that the cartoon shows on Saturday could be used to warn kids about accidents and problems they get into. I wanted you to know that there is a constituency out there that agrees with you on that.

When you did your study for Governor Carey, did you find that alcohol abusers were high users of health care service generally? Was there any way you could——

Mr. CALIFANO. We looked at the hospitals in New York City and we looked at hospitals in other cities in the State, and on any given day many of the people that are occupying the hospital beds in urban areas are there because of alcohol directly or indirectly, accidents caused when they were drunk or abusing alcohol or diseases related to alcohol, and we are talking about 40 to 60 percent of the population of public hospitals. It is a phenomenal drain on the health care system.

It is also true with respect to the criminal justice system. It is important to remember that more than half the people who commit rape are under the influence of alcohol, half the child abusers are under the influence of alcohol, and a tremendous amount of violence in the family is related to alcohol or drug abuse.

Senator DODD. Smoking, I know this is an issue in which you have a minor interest, and I want you to know, Joe, I quit smoking. [Laughter.]

It was ridiculous even to go out and have dinner with this man if you were smoking. You would ruin an entire evening. He was a terrible smoker himself, I want you all to know that. But smoking and alcohol seem to be—there is a strong relationship there.

Mr. CALIFANO. If you want to escalate your chances of cancer enormously, smoke and drink at the same time for extended periods of time, I think there is no question about that.

In terms of deaths, I guess cigarette smoking is the number one killer in the country. It does kill 360,000 people a year. But if you look at social security disability, the combined impact of cigarette smoking and alcoholism in that program is probably over $2 billion a year in social security disability payments. It is staggering.

Senator DODD. You made a recommendation that there be a National Institute on Addiction when you testified before the full Committee a few months ago. I think that is a good idea. There are obviously NIDA and various other agencies of the Federal Government which you would have to fold into that. Do you have any suggestions on how you do that? Have you gone beyond the general note that—whether it is smoking or alcohol or drugs—there is a real addiction problem in the country that is causing a substantial problem, which is what we are saying here this morning?

Mr. CALIFANO. I think the most significant thing we could do in terms of research, would be to create a National Institute on Addiction to deal with alcohol, tobacco, heroin, cocaine, and all drugs, including prescription drugs like tranquilizers. If you combine all of that, it is clearly the number one health problem of the United States.

If you put the research efforts together in one institute—not the clinical programs, I would leave them scattered through their various constituencies—but if we put the research efforts together I think what we would do would be to create a congressional and national commitment of funds and resources to deal with addiction. Addiction is an intractable problem. It is very difficult to deal with. We need our best minds. We have our best minds in the National Cancer Institute, because we have the national commitment. They know that you Members of Congress and Senators are there, you are going to provide the resources they need, so an individual is willing to devote 10, 20 years or his entire life to research in that area. We have not made that kind of commitment to addiction. If we do, I think we will attract some of our finest minds to devote their lives to this effort.

Senator DODD. I agree with you. I think it is an excellent suggestion. I am going to try and put something together along those lines.

Mr. CALIFANO. I would be happy to work with you, Mr. Chairman.

Senator DODD. If you would, that would be tremendously helpful. I think you are right, I do think it is fiscally responsible because there probably is a tremendous amount of duplicative research that goes on with the problem of addiction. I have spent some time at the John Dempsey Health Center at Farmington, Connecticut, associated with the University of Connecticut. For a number of years they have studied people who are the children of alcoholics who have been trying to follow their behavioral patterns as they mature.

Last year as part of the omnibus anti-drug legislation, I sponsored prevention and treatment funding for at-risk youth. Included in that at-risk category are the children of alcoholics. We know already that there is risk involved. As you point out, there is some research going on in the area, but we need longitudinal research. We need to track people over a generation or more. There are research efforts going on, conducted by some highly dedicated people. At the John Dempsey Health Center, they already spent about 15 or 20 years on this issue. They said I was the first politician to come and take a look at the research they are conducting in several small rooms. They are working quietly day after day in this area. If we can get more of a focus on the problem of addiction and studies like those being conducted in Connecticut, they could duplicate it in other places and we could get a lot more information.

I think it is important to note that only about one percent of our medical students' time is devoted to studying alcohol abuse. I am shocked to hear that.

Mr. CALIFANO. Well, one of the terrible problems here is that our health professionals are not good at identifying alcoholics. Often when they identify them, they do not give them the right treatment. It is not unusual for an individual who has got an alcohol problem to have the family doctor say, well, you have got to stop drinking, and then the patient says, well, I cannot sleep at night. The doctor says, well, here let me prescribe some sleeping pills, or, if the patient says I am nervous during the daytime, let me give you some tranquilizers. There is no dealing with the underlying problem, and 6 months later the patient is not only abusing alcohol but tranquilizers and sleeping pills as well.

In the school community, one of the points that the Foundation has pressed is to have teachers trained and counsellors trained to identify children of alcoholics and recognize that as a problem so that they can help the children.

Senator DODD. That is good news. It is good news to hear.

Migs, if I can, a couple of questions for you. Parental consent is a difficult barrier in many States for treatment of children of alcoholics who are minors. I'm glad you raised that in your testimony. Also, I could not agree more on this notion of runaways. Runaway kids are making very adult decisions. In many cases, they are running away not because it is the first option. They have exhausted about every other option. They are making an adult decision in the sense that an adult confronted with the same situation would do just what they are doing when all else failed. Runaway children are not making childish decisions when they are confronted with that problem of alcohol and drug abuse at home and decide to leave.

Obviously, for a child that is aware and wants to do something about familial alcoholism and needs help, there is the problem of parental consent. We have seen this in other related areas with respect to sexual abuse. If a child has been sexually abused and if they want to get some treatment, there may be the barrier of parental consent. Senator Hatch was tremendously helpful on this when he was contemplating a program on parental consent for family planning services in the State of Utah. Our concern was that if a child was encouraged to step forward to get help but that help required parental consent, it would just exacerbate the cycle in many cases.

How do you get around the problem of requiring parental consent to help these children when parental consent may exacerbate the cycle of abuse? We are finding States more sensitive to the problem of parental consent in the areas of alcohol and drug abuse. As Joe points out the risk of physical abuse for children of alcoholics is already high. Can children come forward for help without fear?

Ms. WOODSIDE. When we interviewed study programs in New York State to do this study for Mr. Califano, we found the issue of parental consent was an extraordinarily difficult impediment for youngsters. They simply could not get the help they needed and the programs were very frustrated that they could not give it because legally it was not approved.

It is very, very hard to ask a parent "may I go to treatment, may I get some help for myself," particularly with alcoholism. There is such denial in the family, everybody is pretending it does not exist, and to get parental consent forces the family to say, "Ah, it does exist."

What we have done in New York was very innovative. We approved a regulation several years ago to our code so that children can get help from treatment programs without parental consent if the program feels it is in the best interest of the child, if they do try and get consent and if they can document in the record that they tried to get that consent and they continue to keep doing so later on in the child's treatment. So at least we do have a regulation. We are moving forward. We simply could not let the law continue to be such a barrier, and I think other States could look to that as a way of moving forward.

Senator DODD. Is New York the exception on that?

Ms. WOODSIDE. It is rather exceptional, yes. I think Minnesota also sees children without necessarily getting signed parental consent forms, but it is very unusual.

Senator DODD. Maybe we ought to talk at some point on how to spread the word about the New York and Minnesota statutes to State legislators around the country. They may want to pursue it in their own States.

Ms. WOODSIDE. Yes.

Senator DODD. I mentioned this five- or ten-minute program on a news station on the West Coast—I was struck by a couple of things. First, the parents had obviously enrolled the children in this camp. Second, I was impressed by how freely the children were talking and the kind of assistance and advice they were soliciting from the professional staff at the camp. The children were asking what do I do when I go home and my mother is passed out on the floor?

Ms. WOODSIDE. Yes.

Senator DODD. Remarkable questions were coming from the children on learning how to help take care of their parents in this situation.

Ms. WOODSIDE. We would be very, very happy at the Foundation to work with you. It would be a real service.

Senator DODD. I think there is an assumption that once the alcoholic parent has decided that he or she really does need the help and goes in for treatment, that the problem is well on its way to being solved, and that automatically spills over to the child. I think it might be helpful for us to get some observations on how important it is for children who have been scarred at a very early age by parental alcoholism to be able to continue to get assistance, even though the parents are well on the way to recovery.

Ms. WOODSIDE. Well, we feel that there is a myth that really does need to be looked at very carefully. There is a feeling that if the parent goes in and gets help and recovers, that is going to be sufficient for the child and it really is not sufficient. As we have seen in so many of these pictures, youngsters undergo very bizarre experiences.

Now, parents will say the child was too young, they did not know, nothing took place not in front of them, but we know parents are wrong and childen are listening to every word and very often dragged into the family conflict. Besides that, they live through some very bizarre experiences. There is the experience of denial. When you come down the stairs in the morning and step over mom or dad who is lying there drunk and nobody in the family talks about it, that is pretty bizarre. When a parent has hallucinations or delusions and thinks there are snakes or spiders in the living room, the child does not see or experience anything like that, and the child begins to wonder am I going crazy, am I crazy or is my parent crazy.

There are some very searing episodes that happen when a parent is having a blackout and makes promises, "I will come to your high school play," "I will come to the football game," and never shows up. They made the promise during a blackout and do not recall making it. But, the child still feels pain and suffers; they feel very unloved. We believe that youngsters do deserve help for themselves and that this myth that if the parent recovers is enough, really should be dispelled.

Unfortunately, it is very difficult to get treatment for youngsters, as you said, not many adults go into treatment, and even when youngsters do come into programs for alcoholic adults those treatment programs focus on the adult, they do not know how to treat children. They are not used to children. Maybe they do not even really want to deal with children, which can be a very different breed than adults.

Also, health insurance in this country will cover the active drinking alcoholic, maybe even the family, but that does not mean it covers the children. Finally, treatment programs which say they do family treatment generally mean they see the child once or twice, but that is not really getting help for the child. We think that the children should be targeted for help for themselves, regardless of what happens to the parent.

Senator DODD. That is very helpful and I could not agree with you more. I have kept you both a long time and I appreciate your being here. Again, Migs, we all thank you for the work that you have done in this area. We have a number of other witnesses here today and we would love it if you could stay and listen, but to the extent you cannot we will certainly see that you get all the testimony and the questions raised.

Joe, once again, you are a perennial visitor to these office buildings up here whether it is the budget or cancer or other related areas. We are fortunate indeed that you have maintained an active interest in government and public policy, and I personally thank you for being here this morning.

Mr. CALIFANO. Thank you very much, Mr. Chairman.

Ms. WOODSIDE. Thank you very much.

Senator DODD. Thank you very much.

I am going to invite our second panel of witnesses to come forward. We start with Dr. Marcia Russell. She is with the Research Institute on Alcoholism in Buffalo, New York. I should point out, by the way, for those of you going out, that there are more posters with the artwork of children of alcoholics in the hallway. So I encourage you to take a look at those, if you would.

Before beginning with Dr. Russell and the others, I should also point out that our second panel will focus on the effects of parental and alcohol abuse on children in their earliest years, and our succeeding panels will talk about it in adolescence and adult children. So we will take this in three incremental steps along the way.

Dr. Russell, as I pointed out, is with the Research Institute on Alcoholism, Buffalo, New York. She is the co-author of a review of the scientific literature on this issue for the Foundation on Children of Alcoholics. She is a chronic disease epidemiologist in the Department of Social and Preventive Medicine at SUNY, in Buffalo, and she has conducted research on fetal alcohol syndrome.

So we are honored to have you with us this morning.

Virginia Lapham, Dr. Lapham is the director of the Division of Social Work, Department of Pediatrics, Child Development Center, Georgetown University Hospital, here in this city. She has been a specialist working with the families of special needs children for the past 30 years.

In addition to her work at Georgetown, she teaches a class on fetal alcohol syndrome every semester at the Virginia Commonwealth University and Catholic University. So that is being taught. I heard Joe Califano talk about some of these problems and we would like to address the medical school issue as well, doctor.

Our third witness is Rosemary Tisch, she is the president of Kids are Special, San Jose, California. Three years ago, she founded Kids are Special, which is a nonprofit agency working with children of alcoholics and addicts. Kids are Special runs a school based prevention program and special groups for the children of alcohol abusers.

I should point out that I was talking about that particular program and I hope I did not misstate it, but that little film clip is marvelous. I watched that last night, I have to tell you, Rosemary, I regret that we did not set up some cameras around here today just to show that. I was struck by the very adult response of these kids to questions about what it was like to be home. We are thrilled that you are here this morning.

We will begin with you, Dr. Russell. Again, we welcome you. The rules of the road here are that if you have a prepared statement, all of that will be included in the record. We would ask you to try and limit oral testimony to five or ten minutes, if you can, so that we can get to questions and move on to our other panels.

We thank you for being here this morning.

STATEMENTS OF MARCIA RUSSELL, RESEARCH SCIENTIST, RESEARCH INSTITUTE ON ALCOHOLISM, BUFFALO, NY; E. VIRGINIA LAPHAM, DIRECTOR OF SOCIAL WORK AND ASSOCIATE PROFESSOR, DEPARTMENT OF PEDIATRICS, GEORGETOWN UNIVERSITY HOSPITAL, WASHINGTON, DC; AND ROSEMARY TISCH, PRESIDENT, KIDS ARE SPECIAL, SAN JOSE, CA

Ms. Russell. It is a great pleasure.

Mr. Chairman, as we have heard already, it has long been recognized that alcoholism runs in families. Among alcoholic patient populations, from 30 to 50 percent report having had an alcoholic parent.

Until quite recently, however, it was thought that the tendency of children of alcoholics to themselves become alcoholic was caused by environmental influences. However, there is relatively little scientific evidence available to support this theory.

By contrast, a good deal of evidence has been accumulated to support the existence of a genetic component in familial alcoholism. Although research in this area is complicated by the fact that most people are raised by their biological parents, several methods have been developed to disentangle the influences of heredity and environment, at least partially.

The adoption method is the most powerful, because it provides independent measures of both the genetic and the environmental factors. The results of these studies indicate that male sons of alcoholic fathers whose alcoholism is characterized by adolescent onset, extensive treatment for alcohol abuse, and criminality, are four to nine times more likely than sons of nonalcoholic fathers to develope some alcohol-related problems as young adults. This particular form of alcoholism occurs in males but not females, and seems to be surprisingly unresponsive to environmental influences.

For example, a study of brothers in which one brother was raised by the alcoholic biological parent and the other was raised in nonalcoholic foster homes found rates of alcoholism that were just as high even in the young men raised in a nonalcoholic environment.

There is also a milieu-limited form of alcoholism which depends upon mild alcohol abuse in the parents, plus environmental factors. To date, this has only been demonstrated in males, and although daughters and sons both presumably inherit an alcoholic predisposition from their alcoholic parents, males tend to drink more than females and their lower levels of consumption may protect many women from becoming alcoholics, a protection that may be lost if women continue to increase their alcohol consumption.

The inheritance of alcoholism in women is not yet clear. Daughters of alcoholics have a four-fold excess of alcohol abuse, but only if their mothers are alcoholic, and this may indicate a congenital, rather than a genetic effect. You referred to the fetal alcohol syndrome, perhaps something of that nature.

If in fact the mother is an alcoholic or a heavy drinker, she may have been drinking heavily during her pregnancy and there does exist the possibility that some of the characteristics attributed to heredity of maternal traits may have been influenced by this prenatal alcoholic exposure.

The finding that alcoholism has a genetic component has given rise to some very exciting lines of research. One goal is to determine a biological marker that would identify individuals who have inherited a predisposition to become alcoholic and another goal is to understand the nature of the inherited predisposition.

Tolerance to alcohol is one of the factors being investigated. In young, relatively inexperienced drinkers, the tolerance may be more influenced by an inherited initial reactivity to alcohol than by the drinking patterns themselves. The results of several experiments suggest that sons of alcoholics may inherit a greater tolerance to alcohol's intoxicating effects than sons of non-alcoholics.

It is hypothesized then that intolerance to alcohol may act as a protective factor for alcohol abuse, that is people are less likely to become addicted to alcohol if it makes them sick.

A related hypothesis is that individuals at high risk for alcoholism must drink more than others to achieve positive benefits from drinking, such as relief from tension or anxiety. These are reasons that alcoholics often give for drinking. Again, there is evidence that sons of alcoholics must consume more alcohol than sons of non-alcoholics to achieve the same reduction in tension that the others seek.

The consumption of these greater amounts of alcohol then leads to greater tolerance, and this sets up a vicious circle in which tolerance to anxiety-reducing effects of alcohol may interact to promote continued and increasing drinking.

Finally, research on brain waves in sons of alcoholics also suggests that there are differences which predate the exposure to alcohol, and whether or not these differences influence the way in which individuals respond to alcohol exposure is not yet known.

We have heard that there are over 28 million children of alcoholics. Attention to these children has the potential to improve the prevention and treatment of problems in this very large population. It also has the potential to increase our basic understanding of the etiology of alcoholism in ways that will benefit those who are not the children of alcoholics. This is an extremely important opportunity to learn more about this devastating disease.

Turning briefly to research on children of drug abusers, one finds that there is relatively little information available. Studies on pregnancy outcome have found adverse effects on the fetus associated with heroin addiction, methadone maintenance, and marijuana and cocaine use during pregnancy.

Long-term problems in older children of drug abusers have been demonstrated; however, it is hard to know whether these problems are caused by the parental drug abuse itself or if they can be accounted for by the fact that drug-abusers frequently are more likely to come from lower socioeconomic classes, to have more maternal psychopathology, greater marital instability, and other characteristics that may adversely affect child development.

Well-controlled longitudinal studies of children born to drug abusers are needed to address these issues.

Thank you.

[The prepared statement of Ms. Russell follows:]

CHILDREN OF ALCOHOL AND DRUG ABUSERS

A Brief Review of the Scientific Literature

Testimony prepared for the U.S. Subcommittee on

Children, Families, Drugs and Alcoholism

The Honorable Christopher J. Dodd, Chairman

May 13, 1987

Marcia Russell, Ph.D.
Research Scientist V
Research Institute on Alcoholism
New York State Division of Alcoholism and Alcohol Abuse
1021 Main Street
Buffalo, New York 14203
(716) 887-2507

The assistance of John Searles, Ph.D. in preparing this testimony is gratefully acknowledged.

THE DEVELOPMENT OF PROBLEM DRINKING IN YOUNG ADULT CHILDREN ALCOHOLICS

It has long been recognized that alcoholism runs in families. Among alcoholic patient populations, from 30 to 50 percent report having had an alcoholic parent (Cotton, 1979). One of the few prospective studies of alcoholism done to date found that absence of Southern European ethnicity and number of alcoholic relatives accounted for most of the variance in adult alcoholism explained by childhood variables (Valliant & Milofsky, 1982). The authors interpret their findings as indicating that parental alcoholism influences prealcoholic personality and childhood rearing practices so as to increase risk of alcoholism, but this interpretation has been challenged by Zucker and Gomberg (1986), who feel that both personality factors and parental alcoholism are important.

Until quite recently, it was thought that the tendency of children of alcoholics to themselves become alcoholic was caused by environmental influences. According to this theory, children are likely to experience neglect and distress by growing up in an alcoholic home. Traumatic experiences and lack of a healthy role model may impair their psychological functioning and development as they grow up, leading to increased stress in their lives as adults. Meanwhile, they have learned by observing their parents that one copes with stress by drinking. Drinking to cope with their stress leads to increasingly heavy drinking as tolerance to alcohol's effects develops, and alcoholism follows. While this is an intuitively appealing model, it has garnered little empirical support.

By contrast, a good deal of evidence has accumulated to support the existence of a genetic component in familial alcoholism. Although research in this area is complicated by the fact that most people are raised by their biological parents, several methods have been developed to disentangle the influences of heredity and environment, at least partially. It should be noted, that even when one can identify special populations which allow one to distinguish between hereditary and environmental effects, it is difficult to ascertain alcoholism in parents, foster parents, and their children. Although these difficulties are reflected in the literature, the consistency of positive findings over a broad range of study populations using different methodologies provides strong support for a genetic component in alcoholism. Two of the better methods are discussed below.

Twin Studies: By comparing identical twins who share 100% of their genes with fraternal twins who share on average 50%, it is theoretically possible to separate genetic from environmental effects. This method assumes that environmental factors are similar for both, although some have argued that environments for identical twins are more similar than for fraternal. With few exceptions, the results of studies using the twin methodology suggest a strong genetic component for at least one form of alcoholism (Hrubec & Omenn, 1981; Kaij, 1960; Partanen, Bruun, & Markkanen, 1966).

Adoption Studies: The adoption method conceptually permits the assessment of genetic and environmental factors independently. Genetically unrelated individuals raised in the same home give a direct estimate of shared environmental factors, while genetically related individuals raised in different environments provide an appraisal of genetic influences. The adoption design theoretically yields the most powerful and convincing evidence of a genetic contribution to any trait or behavior under study. Due to the difficulty of accessing adoption records and ascertaining mental health status in the study populations, there have been only a few studies reported that relate directly to the etiology of alcoholism (Bohman, Sigvardsson, & Cloninger 1981; Cadoret, Cain, & Grove, 1981; Cloninger, Bohman, & Sigvardsson, 1981: Goodwin, Schulsinger, Hermansen, Guze, & Winokur, 1973). The results of these studies indicate that male sons of alcoholic fathers whose alcoholism is characterized by adolescent onset, extensive treatment for alcohol abuse, and criminality, are four to nine times more likely than sons of nonalcoholic fathers to develop some alcohol-related problems as young adults. This particular form of alcoholism occurs in males, but not females, and seems to be surprisingly unresponsive to environment. That is, the risk of alcoholism was just as high in sons of alcoholic fathers who were raised by nonalcoholic adoptive parents as it was in their brothers who were not adopted out of their alcoholic family of origin; and, conversely, being raised by an alcoholic parent did not seem to increase the incidence of alcoholism in boys who were not adopted (Goodwin et al., 1974).

The inheritance of a predisposition to alcoholism in women has been less well established (Russell, Henderson, & Blume, 1984). Goodwin, Schulsinger, Knop, Mednick, and Guze (1977a, 1977b) found no excess of alcoholism in the adopted daughters of alcoholic biological parents. Bohman et al. (1981) reported that the daughters of alcoholic mothers, but not those of alcoholic fathers, were four times more likely to abuse alcohol than were daughters with no alcoholism in either biological parent, which might indicate a congenital, rather than a genetic effect.

Adoption studies also suggest that there is a milieu-limited form of alcoholism among males which depends upon mild alcohol abuse in parents plus environmental factors conducive to the development of either mild or severe forms of alcoholism (Cloninger et al., 1981). Although daughters and sons both presumably inherit factors from their alcoholic parents which predispose them to alcoholism, in many of the populations studied environmental exposure to alcohol is much greater for males than females. Failure to observe consistently an excess risk of alcoholism in daughters may be related to culturally protective patterns of low levels of drinking among women.

Previous studies have not always taken into consideration alcohol abuse in both parents. The risk of becoming alcoholic is increased if both parents are alcoholic (Hall, Hesselbrock, & Stabenau, 1983), and there is a tendency for alcoholics to marry other alcoholics, sometimes referred to as assortative mating (Jacob & Bremer, 1986). This is especially true for women--those who themselves are alcoholic and/or who had alcoholic fathers being likely to marry alcoholics (Hall et al., 1983). If, in fact, the mother was an alcoholic or a heavy drinker, she may have been drinking heavily during her pregnancy. Thus, there exists the possibility that some of the characteristics attributed to heredity of maternal traits may have been influenced by prenatal alcohol exposure and/or heredity of paternal traits (Russell et al., 1984). Similarly studies of paternal heredity have often failed to control for maternal heredity and prenatal alcohol exposure.

The finding that alcoholism has a genetic component has given rise to several very exciting lines of research which seek: (1) to determine a biological marker that would identify individuals who have inherited a predisposition to become alcoholic and (2) to understand the nature of the inherited predisposition.

Among the measures that have been investigated is static ataxia (standing stability). Increase in sway is a sensitive measure of intoxication, providing an index of tolerance. In young, relatively inexperienced drinkers, tolerance may be more a function of initial reactivity to alcohol than of drinking pattern (Lipscomb & Nathan, 1980). Lipscomb, Carpenter, and Nathan (1979) have reported that college samples of sons of alcoholics (High Risk [HR]) sway less after a challenge dose of alcohol than similar subjects who are not the sons of alcoholics (Low Risk [LR]), suggesting that HR subjects may have inherited a greater tolerance to alcohol's intoxicating effects. It is hypothesized that intolerance to alcohol may function as a protective factor for alcohol abuse, e.g., people are less likely to abuse alcohol if it makes them sick.

Another hypothesis is that HR subjects must drink more to achieve positive benefits from drinking such as relief from tension or anxiety, reasons often given by alcoholics for drinking (Sher, 1986). During anxiety-eliciting social interactions, HR subjects' heart rates increased more than those of LR subjects, and measures of both skin conductance and heart rate indicated significant dose-by-tolerance interactions (Schuckit, 1983). This suggests that HR subjects must consume more alcohol in order to experience an autonomic effect (presumably associated with reduced social anxiety) comparable to that experienced by LR subjects. The consumption of greater amounts of alcohol further enhances tolerance, setting up a paradigm in which tolerance and the anxiety-reducing effect of alcohol may interact to promote continued (and increased) drinking.

Research on brain waves in sons of alcoholics also suggests that there are differences that predate exposure to alcohol (e.g., Begleiter, Porjesz, Bihari, & Kissin, 1984). Whether or not these differences influence the way in which such individuals respond to alcohol exposure is not yet known.

We have heard that there are over 28,000,000 children of alcoholics. This estimate of the magnitude of the problem is based on data from the 1979 National Drinking Practices Survey, a representative sample of the adult U.S. household population (Clark & Midanik, 1982). The survey found a 10 percent rate of problem drinking, which, if the ratio of children to adults among problem drinkers is similar to that for the population as a whole, would indicate that there are 6,600,000 children of problem drinkers (alcoholics) under age 18 years (Russell et al., 1984). Further, the survey asked about alcoholism/problem drinking among respondents' parents, with positive reports from 11% of the males and 16% of the females, which extrapolates to 22,000,000 children of alcoholics over age 18 (Russell et al., 1984).

Attention to children of alcoholics has the potential to improve the prevention and treatment of problems in this very large population. It also has the potential to improve our basic understanding of the etiology of alcoholism in ways that will benefit alcoholics who are not the children of alcoholics. This is an extremely important opportunity to learn more about this devastating disease and to improve the health of our nation.

Until now this review has focussed entirely on children of alcoholics. This is dictated not only by my research interests, but also by the dearth of information on children of other substance abusers. As summarized by Deren (1986), most research on children of substance abusers has investigated pregnancy outcome in heroin addicts and women in methadone programs. An epidemiologic study of marijuana use during pregnancy reported adverse effects on fetal growth and development (Hingson et al., 1982). Cocaine use during pregnancy is associated with a high rate of spontaneous abortion (Chasnoff, Burns, Schnoll, & Burns, 1985). Few long-term studies in children of substance abusers have been done. Research in this area is hampered by the illegality of the behavior involved and by the multi-problem characteristics of the populations affected. It has been demonstrated that children of substance abusers tend to be developmentally delayed and have problems in school (Deren, 1986). What is more difficult is to determine the extent to which these problems can be attributed to parental substance abuse per se, as opposed to an increased incidence in substance abusers of factors known to impact negatively on child development, such as lower socioeconomic status, maternal psychopathology, marital instability of the home, etc. Well-controlled, longitudinal studies of children born to substance abusers are needed to address this issue.

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Senator **Dodd**. Thank you very much.

Dr. Lapham?

Ms. **Lapham**. Thank you, Mr. Chairman.

I want to commend you for focusing your attention on the vital issue of children of alcohol and drug abusers and particularly to call attention to this being FAS, Fetal Alcohol Syndrome Awareness Week. I think it is extremely appropriate that Mothers Day week was selected for focus on this issue.

Senator **Dodd**. I did not think of it in those terms, but it is a nice idea.

Ms. **Lapham**. When we recall that each year in the United States that there are an estimated 40,000 babies born with physical and mental birth defects that are the direct result of maternal ingestion of alcohol during pregnancy, those of us who work in hospitals are very aware that alcohol during pregnancy is a crisis for the unborn.

In actuality, there are two victims in alcohol abuse during pregnancy. We have heard and will continue to hear a lot about the disease of alcoholism in women and the difficulties of facing up to the problem and getting treatment. To continue the use of of alcohol during pregnancy, however, carries an unacceptably high risk to the unborn fetus. I have prepared written testimony, Mr. Chairman, which I would like to have entered in the record. For the few minutes here, I would like to highlight a few issues of the written testimony and present a case history that I pulled from the records just yesterday that illustrates many of the problems.

Senator **Dodd**. That is no problem at all and your written testimony will be included in full in the record and we will be delighted to hear the case study. Dr. Lapham, I am going to ask you to pretend that this is a class. Unfortunately, you are speaking with your back to them, so really speak up if you would.

Ms. **Lapham**. I would like to mention, parenthetically, that Georgetown University Medical School does include classes about alcohol use and abuse and risks in their curricula and have been doing so for some years. Most of the classes have been doing so for some years. Most of the classes have been in the Departments of Psychiatry, OBGYN and Pediatrics. I would not say that these classes are as inclusive as, or as extensive as they could be.

Senator **Dodd**. Did you yell at Joe Califano before he left? Did you grab him?

Ms. **Lapham**. I actually have an article out of Science that cites Georgetown Medical School as one of the few medical schools that teaches about alcoholism.

Senator **Dodd**. I will see that he hears about Georgetown. I promise you that I will do that.

Ms. **Lapham**. Thank you.

At Georgetown University Medical Center, we see women who abuse alcohol and other drugs in our prenatal clinics, we see them at the time of delivery, we see them when they visit their newborn babies who are often in the intensive care nursery for weeks and months, and we see them later when they bring their children to our child development center for evaluations and learn for the first time that the reason their children are delayed and having learning problems are because of fetal alchohol.

We also see adults of all ages, including those in their seventies, out at Forest Haven, where we run a day treatment program for mentally retarded adults being de-institutionalized. Some of these adults have characteristics of alcohol related birth defects.

The particular case that I wish to mention this morning utilized a number of the services that we offer at Georgtown. This is the case of Charles who was born to a 32 year old woman. It was an unplanned pregnancy and Mrs. A spotted initially, but no treatment was sought or given. Prenatal care was obtained for the first time about the fifth month of gestation. I would like to note here that one of the difficulties in helping pregnant women who abuse alcohol and drugs is that they they often seek prenatal care at a very late time in their pregnancy.

Mrs. A's pregnancy was diagnosed to be twins through sonography at about 24 weeks. At that time, Mrs. A admitted to smoking a pack of cigarettes a day, taking two or three beers daily, plus a six-pack of beer on weekends. Wine and hard liquor were also taken occasionally. Mrs. A said she had also initially sampled marijuana.

Labor began spontaneously at 32 weeks, or about 8 weeks early, again a characteristic of women who abuse alcohol is that the baby arrives early. The twins weighed just under and just over 1,300 grams with Charles the heavier baby Charles' APGAR scores were one and seven, and the second twin Sandra had APGARS of one and five, and had to be resuscitated right after birth.

Charles, was in the intensive care unit for about a month, with respiratory problems. He was discharged on an apnea monitor and he experienced anemia during his first four months.

We have just seen this child at the age of 4½ months. His mother states that he has been doing well since his discharge from the nursery. He is eating. His stooling pattern is normal. He can smile at the age of 4 months. He can follow with his head and he appears to be alert visually and auditorally and has good head control. Overall, he is about 1 to 2 months delayed.

His twin, however, is still in the hospital. Charles has fetal alcohol effects. His twin, Sandra, has the full fetal alcohol syndrome, and I think this again points out how babies from the same pregancy can be affected differently by alcohol consumption of the mother.

The mother says she is in good health. She continues to drink. She has two older children, a 4-year-old with hyper-activity and learning problems. She has a 15-year-old who has never been a good student. As in many other situations, we see with this family, that alcohol related birth defects get worse with each pregnancy.

Mrs. A's own mother died at the age of 48 of cirrhosis secondary to alcoholism. Her father died in the service. So, we see an intergenerational pattern of alcohol use, which again is not uncommon among children of alcoholics.

At this point, I would like to make a clarification of just one minor difference from what was said earlier about my teaching assignments. I teach one class each semester on fetal alcohol syndrome, rather than a whole semester on the topic. And it is always a surprise to find these young, mostly women, graduate student (in spite of all of the 1981 Surgeon General's warning and all that we have known since 1973 of fetal alcohol syndrome) do not know the full consequences of the use of alcohol during pregnancy. Some of the students know a little about alcohol effects but think it is only heavy drinking that matters. They also think it affects only poor women, and not themselves.

I would just like to summarize my comments at this point with a reminder that there are an estimated 40,000 babies born each year in the United States who suffer life long disabilities from fetal alcohol, 4,800 with fetal alcohol syndrome, and 36,000 with fetal alcohol effects, and this probably is only the tip of the iceberg. We think now that many of the children we are seeing with attentional deficit disorders, with learning disabilities, and with behavioral disturbances may also be the innocent victims of fetal alcohol.

Alcohol related birth defects affect all segments of our society. While we more often diagnose it in women of lower socioeconomic classes, one reason is because they are more open and more willing to admit their drinking habits. The upper income women can afford private care and go to physicians who may label their drinking as something else.

The effects of alcohol on children are life-long. We have, as pointed out earlier, the resulting mental retardation and other central nervous system dysfunctions which are entirely preventable at least from a physiological point of view. We have people in the fetal alcohol field who think that instead of 1 in 400 alcohol related birth defects to 750 live births, that we are going to eventually find the incidence more like 1 in 100, and that alcohol is the leading cause of mental retardation.

Family stresses, including those related to alcohol abuse, often lead to child abuse and neglect. Sometimes this occurs even before a baby is discharged from the hospital after birth. We involve child protective services when mothers come to visit their babies in the intensive care unit inappropriately, or when the mothers come inebriated or when they do not come to visit at all. Sometimes babies of alcoholic women end up in the child welfare system before ever going home.

Senator Dodd.. Right out of the hospitals?

Ms. Lapham. Right out of the hospitals. Mothers who cannot provide a safe environment because they are still actively involved with alcohol may—voluntarily relinguish their baby for foster care. Other times, as the result of visits by agencies such as the Visiting Nurse Association, protective services will determine that the baby cannot go home. I believe that babies with alcohol effects are the largest group of infants entering foster care at this point.

I would like to close my comments (although I have other comments and several recommendations, in my written testimony) with the hope that the future of fetal alcohol syndrome and fetal alcohol effects will parallel that of congenital rubella syndrome. For many years in New York, I worked with families of children with severe handicaps resulting from German Measles or rubella during pregnancy. German Measles was not generally harmful to anyone except unborn babies.

The Nation mobilized an educational campaign and then put money into discovering a vaccine that has virtually eliminated congenital rubella syndrome. I would hope, Senator Dodd, with your good efforts, that we can mobilize a similar educational effort for prevention, and education and funding for services so that 20 years from now we can consider fetal alcohol syndrome and fetal alcohol effects a thing of the past, as we now do congenital rubella syndrome.

Thank you.

[The prepared statement of Ms. Lapham follows:]

TESTIMONY

OF

E. VIRGINIA LAPHAM, PH.D., ACSW

Director of Social Work and Associate Professor
Department of Pediatrics, Georgetown University
and
Associate Director, Department of Social Work
Georgetown University Hospital

for
the
UNITED STATES SENATE
COMMITTEE ON LABOR AND HUMAN RESOURCES
SUBCOMMITTEE ON CHILDREN, FAMILIES, DRUGS AND ALCOHOLISM

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Mr Chairman, Members of the Senate Subcommittee on Children, Families, Drugs and Alcoholism; I would like first to commend you for focusing national attention on the vital issue of Children of Alcohol and Drug Abusers. I also wish to thank you for the opportunity of being invited to present testimony on one aspect of this important topic, specifically:

Children with Alcohol Related Birth Defects and Their Families.

Each year in the United States, an estimated 40,000 babies are born with physical and mental birth defects that are the direct result of maternal ingestion of alcohol during pregnancy. Alcohol during pregnancy is a crisis for the unborn. The birth of a child with alcohol related birth defects is also a crisis for families and for society.

As part of my work at Georgetown University Child Development Center and Department of Pediatrics as well as Georgetown University Hospital, Department of Social Work, I have both direct involvement and supervisory responsibilites for social work with high risk pregnant women, with families of infants in an intensive care nursery, and with interdisciplinary assessments of infants, children and youth who have a wide variety of chronic illnesses and disabilities including alcohol related birth defects. Additionally, I spend one day each week in a treatment program for severely mentally retarded and multihandicapped adults who are being deinstitutionalized. Some of these adults also evidence disabilities related to fetal alcohol.

In retrospect, I can also say that some of the children I worked with over the past three decades, had alcohol related birth defects. In some cases, I was aware of alcohol abuse in the family, but alcohol related birth defects had not been defined, and I did not understand the full causal relationship between alcohol and its deleterious effect on fetal development.

ALCOHOL: CRISIS FOR THE UNBORN

In 1973, Fetal Alcohol Syndrome (FAS) was officially identified and labeled by dysmorphologists Kenneth Jones and David Smith at the University of Washington in Seattle. FAS is categorized by a cluster of birth defects that include the following:

- growth retardation
- abnormalities of the face and head
- central nervous system dysfunction
- malformation of other organs or systems

Fetal Alcohol Syndome is one of the three leading causes of mental retardation and the only one that is entirely preventable. The estimated incidence of FAS in the United States is approximately 1 in 750 live births or 4,800 babies each year.

Infants who display less than four of the characteristics listed are considered to have Fetal Alcohol Effects (FAE). The less severe effects are believed to be associated with smaller amounts of alcohol consumption during pregnancy and/or different sensitivities of the fetus to the amount of alcohol that crosses the placental barrier. For some infants, one drink may be harmful, whereas in other cases, large amounts of alcohol seem to have little effect. The effects also vary with the stage of fetal development althrough no period of pregnancy is considered safe and without risk. Estimates of FAE are that 36,000 newborns each year may be affected.

Questions are also being raised by child development researchers about the relationship between fetal alcohol and the large number of children who are identified at school age as having Attentional Deficit Disorders, Learning Disabilities, Behavioral Disturbances, and other symptoms often related to neurological dysfunction. If this relationship is found to be accurate, the actual numbers of children affected by alcohol inutero may eventually be found to be several times the current estimates, perhaps as high as 1 in 100 live births. A large number of spontaneous miscarriages are also considered due to alcohol use.

Fetal Alcohol Syndome and Fetal Alcohol Effects are life long impairments for the children affected. Early identification and intervention can help to improve the overall functioning level of the child by maximizing strengths and preventing social and emotional problems. Many of the affected children, perhaps most of the affeected children, however, are not receiving needed services at an early age. An illustration of this is an 11 year old girl recently seen for interdisciplinary evaluations.

Alice, was brought by her parents for evaluations because she was continuing to be behind her peers in school. She was a small, quiet child who always sat in the front of her class room so she could see the board better. Alice's parents knew she looked a little different than their other children and that she had some abnormal joint development in her wrists. At the time of the evaluations, the parents were concerned that Alice was losing weight and that the teacher was talking about Alice not being ready to go to 6th grade at another school. The pregnancy history taken of Alice indicated that Alice's mother "occasionally" drank alcohol. After extensive medical, nutritional, psychological, speech and language, social work, nursing, audiological, gross and fine motor, neurological, and other tests showed that Alice had a small head circumference, mild mental retardation, was the size of the average 7 year old child, had more closely set eyes than did other members of her family and also had other subtle facial abnormalities. After metabolic, chromosomal and other tests ruled out other possible etiologies, Alice was determined to be a child with Fetal Alcohol Syndrome. With the help of the case manager and the social worker working with the school district, Alice will soon be placed in an appropriate educational setting. The nutritionist is working with the family on an adequate diet for Alice. Even with this input, Alice will be unlikely to attain the adult level of functioning she would have if she had been identified and provided with interventions since infancy.

FETAL ALCOHOL: CRISIS FOR FAMILIES

Babies with alcohol related birth defects are born to parents with a wide range of family characteristics across all income and educational levels, racial and ethnic groups, age of parents, number of other children, and geographic locations. The one thing they have in common is that the mother used alcohol during part or all of her pregnancy.

Some babies are born to families in which the mother's drinking is done without knowledge of the consequences. In one case, the women's physician even encouraged her to relax with a glass or two of wine with dinner each evening and she had not been able to stop with that amount. This mother may be one of those individuals with a genetic predisposition to alcoholism in which the individual has no control over the drinking from the first taste.

In another case of a mother with two older normal children whose husband had taken a job that required extensive periods of time away from home, the mother did binge drinking to try and cope with her lonliness. In this case, the baby was diagnosed with FAS soon after birth and the father learned for the first time about his wife's drinking. He was consumed with guilt for leaving his wife alone during the pregnancy while the mother also felt guilty about not being able to control her drinking.

With increased alcohol use among adolescents, some severely affected babies are born to teen mothers. Often these young women from high income as well as low income families have poor nutrition during pregnancy. When these adolescent mothers are also single and have inadequate or late prenatal care, the problems for the fetus may be additive and the outcome even worse. For these adolescent mothers and other mothers with additional life stress problems and few social supports, the care of a baby with birth defects is highly problematic.

Babies born with fetal alcohol effects are often difficult to care for. Because of their small size and birth anomolies, they frequently remain in intensive care nurseries for weeks and even months. Their impaired nervous systems make them irritable and they are not easily soothed by being held and cuddled. Sometimes they even have an aversion to touch and withdraw from the affection of their caretakers. The babies are often difficult to feed and may experience failure to thrive. Their development is slow, eye contact is poor, there are fewer smiles and the babies provide less satisfaction in parenting than normal babies. It is difficult for any parent to provide an optimal family environment for these babies and for parents who expected to have a laughing, cooing baby who would show unconditional love for them, the disappointment and difficulties of caring for the infants puts them at high risk for neglect and abuse.

The mothers of babies born with FAS may also need special attention. Women who drink alcohol, do so for a variety of reasons and with varying degrees of control. Women who drink primarily to facilitate socialization and can stop drinking at any time, are probably the most amenable to an educational approach to cease drinking during pregnancy. Some women in this category may be risk takers and drink periodically anyhow believing they will beat the odds, and some do. They may even cite the data that show that "only 40 per cent" of heavy drinkers have FAS children so how can an occasional drink be harmful.

Alcohol may be used by women (and men) at times as a way of dealing with emotional problems or boredom. Since there is still somewhat of a double standard for alcohol use that includes less societal and family tolerance of inebriation by women, they are more likely to drink alone and to try and conceal their drinking. This is believed to be especially characteristic of middle-class women who are home alone during the day. These women generally avoid treatment centers and consult with private physicians who treat them for something besides alcohol abuse. Unless the emotional issues are addressed in other ways, women in this category are likely to periodically lose control over their drinking and perhaps have children with more of the fetal alcohol effects.

Women who are physically dependent on alcohol and drink five or more drinks daily are at highest risk for having babies with the full blown Fetal Alcohol Syndrome and the least likely to abstain from drinking on their own. These are also the women who often get poor prenatal care and may have poor nutrition which adds to their problems and the problems of their unborn children. Intensive day treatment programs or even inpatient treatment may be indicated for pregnant women who are alcoholic but denial is common and compliance rare. While the media has cited a few instances of pregnant alcoholic and/or drug abusing women being forced into treatment, this raises other kinds of ethical and legal questions of rights and responsibilities.

The children of alcoholic women often end up in the child welfare system either voluntarily because the parents are unable to provide care or involuntarily because of neglect or abuse. Sometimes this occurs even before the baby is discharged from the hospital. Parents who fail to visit their babies in the intensive care nursery or who visit while under the influence of drugs or alcohol are reported to protective services for a home assessment before the hospital will discharge the baby. If the home is found unsafe, the baby may be turned over to a foster care agency and eventually released for adoption.

Adoptive and foster families are another category of families who often need help in understanding and providing optimal care for babies with alcohol related birth defects who already have one strike against them. In one case of a single adoptive parent: the mother knew her 4 year old daughter had Fetal Alcohol Syndrome but as it turned out she didn't know what FAS implied for her daughter's development. She placed the child in a highly competitive private school with class sizes of 30 with one teacher. Each day the mother received reports from the school of her child's "bad behavior." The self esteem of the child and the mother-child relaionship were at risk when this mother joined a parent support group and received help from the other parents and from the group leader.

Little has been said so far about the role of fathers and siblings of children with alcohol related birth defects. Thus far, alcoholic fathers have not been highly implicated in causing fetal alcohol related birth defects although relatively little research has looked at this question. The supportive roles of fathers is crucial to the social and emotional and well as economic well being of the families. There is increased risk of marital tension resulting from the birth and care of a child with alcohol related birth defects.

FETAL ALCOHOL EFFECTS: CRISIS FOR SOCIETY

The human and economic costs of having more than 40,000 infants born each year with Fetal Alcohol Syndrome and Fetal Alcohol Effects can only be surmised. The initial costs of 24 hour care in intensive care nurseries, medical and rehabilitative follow-up, special education, therapies, vocational or sheltered workshop training, adult underemployment or unemployment, residential care or supervision, and income assistance are all financial considerations to society. When children end up in the foster care or other branch of the child welfare system, the costs to society further increase.

One analysis of costs associated with FAS produced the following 1980 estimates: $14.9 million for health treatment of babies born with FAs; $670 million in total treatment costs for the 68,000 FAS children under the age of 18; $760 million in treatment costs for 160,000 FAS adults; and 510.5 million in indirect productivity losses.

BARRIERS TO PREVENTION OF ALCOHOL RELATED BIRTH DEFECTS

. Lack of education about the effects of alcohol on fetal development. Although, in 1981, the Surgeon General of the United States issued a health advisory recommending that women who are pregnant or who are considering pregnancy should abstain from alcoholic beverages, some women have not yet been reached with this message. Other women who have an awareness that drinking during pregnancy may damage their baby believe that two or three drinks a day are safe during pregnancy. Still, other women know the data and decide to continue drinking believing they will beat the odds.

. Social Use of Alcohol Since the repeal of prohibition, alcohol has become a common and familiar part of adult life in most social situations. There is reluctance on the part of family members, friends and medical professionals to advise pregnant women against drinking. This is particularly true of higher income women who are assumed to know the effects of alcohol on fetal development and also presumed to be able to make good judgements.

. The Special Needs of Female Alcoholics The female alcoholic is often in double jeopardy because of myths, misconceptions, and stereotyping of women and alcohol. The intoxicated male is often treated with indifference, perceived as amuisng or pitied for his drunkenness. In contrast, the intoxicated female is held in contempt for drunken behavior and perceived as a "fallen women." These social attitudes may be influential in causing women to hide their alcoholism. The ways in which alcohol affect women has also received little attention as most studies have been made with males. The recent media releases of an association between alcohol use and breast cancer may be an example of this difference.

. Alcoholism Counseling Strategies Counselors in the field of alcoholism and drug abuse have as their primary focus the rehabilitation of the individuals in treatment. They seldom deal with the effects of alcohol on a fetus. On the other hand, professionals who specialize in birth defects, including FAS, seldom lay claim to knowledge of how to treat mothers of the children they diagnose with FAS. Since there is some evidence to suggest that subsequent pregnancies produce children with even more severe alcohol related birth defects, intervention with mothers of an FAS child is essential for prevention. Some mechanism needs to be considered to encourage these two groups of professionals to work and communicate more closely.

SUMMARY

1. An estimated 40,000 babies are born each year in the U.S. with alcohol related birth defects. The actual figures may be higher.

2. Alcohol is a crisis for the unborn and subsequently for families and for society.

3. Alcohol related birth defects affect all segments of society.

4. The effects to the children are life long.

5. The resulting mental retardation and other central nervous system dydfunctions are entirely preventable from a physiological perspective.

6. More information is needed about successful ways to help women refrain from alcohol during pregnancy.

7. Family stresses, including those related to alcohol abuse, may lead to abuse and neglect and further add to the problems of the affected children.

8. The U.S. public is not sufficiently aware of the risks of alcohol during pregnancy.

9. The human and economic costs of alcohol related birth defects are staggering to consider and need to be calculated in more precise dollar figures.

10. Alcohol and Drug Treatment Counselors and Professionals who diagnose and treat children with alcohol related birth defects have little knowledge and understanding of each other's expertise and interventions.

11. Research in prevention and treatment of alcohol related birth defects is inadequate.

Recommendations

1. Federal government research priorities should include support of demographic and epidemiological studies to provide better data on the incidence and prevalence of alcohol related birth defects.

2. Preventing alcohol related birth defects should be made a health priority and funding allocated for educating the public

   - in the media
   - in the schools
   - in professional offices
   - in ads for alcoholic beverages
   - with warnings on containers of alcoholic beverages

3. Physicians and other health care providers should learn to recognize and treat (or refer for treatment), individuals with alcoholism and related problems. This includes more emphasis on the disease of alcoholism in medical schools and in continuing education programs. Schools of social work and related fields should include information about FAS and treatment in all of their health curricula.

4. Research should be funded to pursue inquiry into the adverse effects alcohol related birth defects have on the lives of affected children, family members and other care givers, so ways and treatments can be developed to minimize those impacts.

7. The alcohol industry should take responsibility for warning women of child bearing age about the influence of alcohol on fetal development instead of aiming their advertising to increase alcohol consumption among this population. Some financial responsibility should be provided by the alcohol industry for the treatment and education of children with alcohol related birth defects.

8. Children with FAS could be considered one of the categories eligible for catastrophic illness and long-term care.

Senator Dodd. Thank you very much, Dr. Lapham, and we will have some questions for you in a few minutes.

Ms. Tisch, we thank you for coming. You have had a long trip and we welcome you.

Ms. Tisch. Thank you. I really appreciate also the hearings on the children of alcoholics and addicts, and thank you for the comments on our videotape. We are very proud of that. It was well done.

Senator Dodd. She did a very good job. With all due respect, there has been a lot of criticism in the news media in the last week or so—

Ms. Tisch. Yes, and that is an exception.

Senator Dodd. Well, not necessarily, but it is a well done show.

Ms. Tisch. Yes.

Senator Dodd. It was very well done. I did not get the reporter's name, but she asked just tremendously sensitive questions and I think she did a tremendous job with children, really excellent.

Ms. Tisch. Thank you.

I would like to start with a couple of quotes from children that we have worked with. "My mom is allergic to her juice," a 3-year-old daughter. "I didn't give them arms, I'm afraid they would hit each other," a 9-year-old girl talking about a picture she had drawn. "Sometimes I just sit in a chair and become part of it, so my dad won't see me."

Why do we work with children of alcoholics. They are the children that are at highest risk for chemical dependency. Walk into an Alcoholics Anonymous meeting—50 percent at least of the people in that room say they had an alcoholic parent. Another 35 percent of these children will probably marry someone who is chemically dependent.

Problems of children of substance abusers are:

Unwanted pregnancy (the rate for these children is very high for teenage pregnancies); Fetal alcohol syndrome (of course, is going to be very highly related if we are talking about a 50 percent addiction rate, and there are pregnant teens as well); Half of juvenile crime is committed by children of alcoholics, according to NIAAA. (We have a volunteer group in Santa Clara County called Friends Outside that works with our Juvenile Hall. They are not our employees. The first time I heard her present was a couple of months ago—100 percent of the kids 12 to 14 in our Juvenile Hall are children of alcoholics) School dropouts, delinquency, runaway, suicides, abuse and neglect, learning disabilities and hyperactivity that we were just talking about—60 percent of the kids in our special ed classes in our district that I know of probably have an alcoholic parent, and this is a high-income district. This is a district that says they do not need our service.

Compulsive over-achieving, kids that do extremely well—one of the girls we worked with in fifth grade, the teacher said was one of the most perfect children she has ever seen in 30 years of teaching—straight A's, she played two instruments with county awards, absolutely outstanding child; and

Ninety to 100 percent of the people seen in the employee assistance programs in Santa Clara County, Silicon Valley, are adult children of alcoholics.

Kids are Special has been together for only three years. It is a nonprofit agency based in San Jose, California, dedicated to serving only children of alcoholics and addicts. What do we do? We run education support groups for these children.

Three years ago, we had no groups and no children. Now we are seeing 100 kids a week. We are working with parents in what we call a parent support group. We see about 40 parents a week. We train about 20 professionals a month. We have put together a curriculum to help other people how to work with children of alcoholics. We have a very active community education component. Most recently, we had our executive director, one of our clients, a child, and her parent on The Hour Magazine. We were not staffed to answer the phone calls coming back from that presentation. That client, which is interesting, is a 12-year-old girl who was only diagnosed for fetal alcohol syndrome this year. It takes time sometimes for this to show up.

We run a school prevention program that has three components: teacher education so they can identify the children, parent workshops defining what a high-risk child is, and then on-campus groups, where we see about 250 kids a week.

We have just started a student assistance program in the high schools. The schools are willing to pay some of the costs next year, after having counselors just 1 day a week on the campus seeing about 100 kids. And we offer a kids camp—that videotape that you were talking about—that provides residential treatment.

What are the kinds of people that we are seeing? About half the families are single parents. Usually the mother calls us. Usually there are kids screaming in the background. She is afraid, she is under a lot of stress. Usually the drinking has stopped in the families we are working with. Only about 25 percent of the people that we work with have drinking parents, and yet they still need help. Why? Because they do not want their kids to suffer like they did.

Most of the parents are adult children and do not know what to do. They were raised by alcoholic parents and they do not know how to break the syndrome. They do not know how to appropriately discipline. All they know how to do is hit, maybe not hit with a broomstick like they were, they hit with something soft like the end of a duster, which is the last abuse case I had to report.

The younger the child, the more important for them to get help. If alcoholism starts when you are young, you have never seen what we call a normal family, and the Just Say No program does not work for these kids. They go home and they see a parent that cannot just say no and they cannot put the facts together.

What do I see as the needs? We need money. I could not present a written testimony today because I have had four grant proposals due last week and this week. Foundations have been carrying the load for us. We have had support from the Johnson and the Packard Foundations, United Way, Valley Foundation, and Community Foundation helped me get here today. They cannot carry the load.

When we went from a budget of $6,000 to $250,000 this year, foundations can no longer carry us. We have got to have help at the State and Federal level. So far we have received nothing from State or Federal. Our county came to us this fall and said they would like to do something for children, and gave us $8,000. The rest of that has been private money.

We need to train professionals. We cannot run those ads on Saturday TV comedies and the comics because there is nobody to provide the services. It is going to hurt even more if those kids learn that there is something out there and have no one to turn to. First, we have got to educate the community and provide agencies for them to turn to. The laws do not allow us to work with kids without the parent permission in California. Those kids on the videotape parents had given permission. They are in recovery. We cannot do it. We kind of go around the laws with our teens, because there is a law passed in our State allowing counseling with teens around sexual counseling. We kind of turn that and use it to work with teens, but we cannot with the younger kids.

And we need evaluation. We very desperately need evaluation of our program to find out if it is working and if other programs are working. And we need the longitudinal studies, what happens, do they use, do they come in earlier, what do they use, how does it all work.

The problem hits all areas, ethnic, racial, educational, income. Denial is very high at all levels, but the worst is the high-income level. Professionals do not see it as we have been saying here. I come from Saratoga, which is a residential community for Silicon Valley executives. That school district has said it does not need our services. The only one in the county that has said that. They will give us money. They gave us room to start the agency, but they do not need the services.

Kids are Special was a dream. It was my dream 3 years ago, because I am a woman alcoholic in recovery, and two of the children I have talked about are my own children. The youngest one that said, "My mommy's allergic to her drink," is my 3-year-old daughter. The perfect child in fifth grade is now my 13-year-old. My family is in recovery now. My kids receive services because I put something together and have had someone else work with them.

The perfect child was in trouble last year and my youngest child is doing very well. But only 5 percent of the children of alcoholics receive help. We are the only agency in northern California working with children of alcoholics. We need more services. These are indeed the forgotten and neglected children and they need your help.

Thank you.

Senator DODD. I thank you for that testimony. I do not know what you would have sounded like if you had prepared your testimony.

Ms. TISCH. I prepared it this morning in the hotel room.

Senator DODD. I find some of the best speeches I ever gave are ones from the heart. I thank you for coming here this morning.

I do not have a lot of questions for you because you have anticipated a lot of them in your testimony and remarks, but there are just a couple. It is not an exaggeration, in fact it may be an understatement to say that a child born with alcohol or drug related problems is automatically at risk for the good part of their lives. That child begins life with a significant disadvantage, both physically, emotionally, and in almost every category it seems you have touched on. He is just starting out with a handicap if he is born with that particular problem, is that correct?

Ms. TISCH. Right.

Senator DODD. I am intrigued by the studies of the risk that children of alcoholics may become alcoholics themselves. You may have heard me talk about the work being done at the University of Connecticut, Dr. Lapham, to look at control groups and groups of children of alcoholics over time to determine the likelihood that they will become alcoholics or substance abusers themselves.

There are three women testifying here, I am fascinated about this notion that even though female children of alcoholics, may not become alcoholics themselves, they are inclined to marry alcoholics. How does that get explained? I have seen the statistics. I do not necessarily argue with it, but I do not understand it. Why? What is there—I mean, I understand the genetic factor that may cause someone to become an alcoholic, in their physiology, but I do not understand why a person who has grown up in a situation that was so harmful would upon marriage gravitate to a situation that was going to be duplicative of the kind of pain they grew up with.

I understand if that happened occasionaly but it is the high incidence of it that I am intrigued by.

Ms. RUSSELL. It is not well understood. Part of it is that if the women themselves drink and spend time in bars, they meet people who drink, and part of it is that they seek out people who drink like they do, so they are comfortable with their own drinking.

Another part of it is that maybe they put up with a man who drinks if they have lived with it in a way that another woman might not put up with it, but I share your puzzlement. There are cases of women who met and married men before they became alcoholic, which suggests that they somehow pick out men who will become alcoholic later. It is probably a psychological factor that we would understand better if we could study it.

Senator DODD. Well, is it the expansive personality type that is inclined to be alcoholic? Do they seek stimulus to maintain a high level of gregariousness and so forth?

Ms. RUSSELL. That could be part of it.

Ms. TISCH. I think part of it also is that so often they marry the potentially alcoholic person before they are alcoholic, and they are seeking someone that comes from a similar family, you know, we marry what we kind of know, we always seek similar things, but we do not see the alcoholism when you first begin the relationship, the alcoholism may not be active.

What is interesting about this also is so often you see divorce come out of this and the women marry again alcoholic. If someone has been married and they go into a divorce situation, you can see them sometimes two and three marriages in a row marry someone who is an alcoholic, until they get some treatment and see what the codependency part of the disease is about. That is part of why it is really important for family treatment.

Senator DODD. That is the triumph of hope over experience, is it not?

Ms. TISCH. No.

Senator DODD. The data—again, you have referred to it a bit, Dr. Russell. You have heard me mention this morning, that we have sent letters to the administration trying to get some additional information on the children of alcoholics. We are trying to jump-start some activity by the Executive Branch on this issue. This has not just been a failure of this administration but I think it has been a failure of all of us to pay more attention to this question. We need to try and start developing that data bank, a reliable data bank.

Too often on some of these issues, we have had a lot of data that gets either exaggerated or under-estimated, and it distorts our ability to legislate effectively. It is so important that we get valid statistics.

The national statistics on the prevalence of cocaine or heroin addicted babies, it seems to me by now we ought to be getting better information on such matters as the national statistics about the prevalence of cocaine or herion addicted babies. Why are we not?

Ms. **Russell**. Part of the answer to that question I think has to do with the illegality of this substance abuse, and it is also I think related to the fact that these are multiproblem people, so that the substance abuse is simply one aspect. As Dr. Lapham pointed out, many of these women do not come in to get prenatal care until very late in their pregnancy.

Senator **Dodd**. Any other comments from either of you two on that? Does that seem to be the reason?

Ms. **Lapham**. Like you, I am not sure I know the reason. I think there are a lot of personality theories but I am not sure that I want to put my foot into that one, because there is a dispute in the field now in psychiatry, in social work and so forth as to how much personality and alcohol use and abuse or drug use and abuse are related to dependent personalities and that sort of thing. It all gets debated, but I do not know the answer to that.

Senator **Dodd**. Let me ask you something else. You are talking to a layman on this issue. I have done a lot of reading about it, but I do not have the kind of experiences you do.

The other day a report was issued—I think it was by the New England Journal of Medicine—saying the likelihood of women contracting breast cancer increasing by about 60 percent if the women are moderate drinkers. And, we are not just talking about what we call traditionally hard liquor.

I am wondering if maybe we are getting some confusing signals here. I was struck by your case study, Dr. Lapham. You talked about your case study not necessarily being an alcoholic. You talked about someone who had a six-pack of beer on a weekend, would have some wine or a few drinks during the week, occasionally smoked some marijuana and a few other things. She was an abuser, you might argue, but not an alcoholic. I am wondering if maybe we shouldn't be a little more honest and say you do not have to be an alcoholic to create problems for a newborn.

Ms. **Lapham**. That is right, that substance——

Senator **Dodd**. You can be an alcoholic—I have a very good friend of mine who is an alcoholic, in fact a former Member of Congress. He cannot tolerate one drink. I think too often we associate the quantity of alcohol with alcoholism and fail to recognize that in many cases they cannot have one drink without having a bad reaction. The abuse of the substance here may be something far short of what we traditionally call alcoholism, and that may be enough to create the kind of physiological problems with new-born infants—am I right on that?

Ms. **Lapham**. Absolutely right. I think you have made two points. I think that there are differences in the way alcohol affects one woman to another and that indeed we see alcohol effects occasionally from what would be considered mild drinking or even just drinking during one part of the pregnancy, whereas we also see women who are the heavy drinkers, the more than five drinks a day. I think today there is something like only 40 percent of them who will have children with fetal alcohol syndrome, and that part of the reason this risktaking that I do not understand about women is that they will continue to drink, often knowing the data, saying that somehow they will magically be one of those who is not affected, and sometimes they are not.

Senator **Dodd**. Would it be your recommendation that any woman who knows she is pregnant not drink during the pregnancy?

Ms. **Lapham**. Absolutely. I am not a physician, but that would be my recommendation from working with affected children and their families.

Senator **Dodd**. And what about other stimulants? Obviously drugs are a problem. Smoking, I presume, is as well. And rather than set a level, you would say cut it out entirely during that period?

Ms. **Lapham**. I would say cutting them out entirely would be the safest course.

Senator **Dodd**. Would the failure to do so raise the risk?

Ms. **Lapham**. Absolutely, and probably includes other things like caffeine.

Senator **Dodd**. I am having a hard time hearing you.

Ms. **Lapham**. I am agreeing that alcohol and caffeine and nicotine and all of these other things should be totally avoided during pregnancy, if at all possible.

Senator **Dodd**. Are you an exception on that, or do you think that is a general consensus in the medical profession?

Ms. **Lapham**. Oh, I think all of the literature that I have been reading on the topic says that today.

Ms. **Russell**. I want to perhaps not disagree with this, but point out that it is important to avoid harming women who find out that they are pregnant and become very worried about having had a glass of wine with a meal before they recognize that they were pregnant. I think we all have to realize that the likelihood of a small glass of wine with a meal is extremely unlikely to have an adverse effect on the fetus, and that the effects that we have been talking about today are associated with very large amounts of alcohol in chronically alcoholic women.

Senator **Dodd**. Now, wait, wait. That is why I asked earlier about the quantity.

Ms. **Russell**. Well, I would like to comment on this case history because we have the woman's report of what she drinks but it is entirely possible that she drank more than she admitted drinking, so that we cannot say, well, these are the kinds of problems you get when you have a six-pack on a weekend. It is not quite so clear-cut.

The other factor is that a six-pack for a woman has a very different effect on her than it would on a man, because she is usually much smaller than a man, and this six-pack gets diluted in her body water. So if a man has more body water to dilute the six-pack, his blood alcohol levels are going to be lower and hers will be higher, and there are differences in body fat as well. We women have a larger percentage of body fat, and alcohol is not diluted in the body fat compartment. So these two things lead to higher blood alcohol levels in women.

The stage of alcoholism has an important effect on the effect of the amount of alcohol on the fetus. So it is complicated. I am certainly not recommending that women drink during pregnancy, that is not my point. I just do not think, as you said earlier, that we should overstate the case and leave anyone thinking that having had one drink is necessarily going to——

Senator DODD. Well, I do not think anyone was suggesting that. It is a general proposition that——

Ms. RUSSELL. I think that the Surgeon General has recommended that women abstain during pregnancy, and this is a fine, conservative recommendation.

Senator DODD. Do you find any distinctions between beer, wine and alcohol in terms of consumption. Would you make recommendations that beer is okay, wine is okay, but stay away from vodka, gin, scotch, whatever, or do you just say across the board?

Ms. RUSSELL. We are saying that if you do not drink, then there is no risk that your child will be harmed. In the studies that have been done on specific beverages, there does seem to be more of a risk associated with beer drinking.

Senator DODD. In beer drinkers?

Ms. RUSSELL. Yes, a couple of studies found that.

Senator THURMOND. What was the statement about that?

Senator DODD. Greater risk with beer drinkers.

Senator THURMOND. Greater risk?

Senator DODD. Yes.

Ms. LAPHAM. I have no comment on that.

Senator DODD. No comment on that?

Ms. RUSSELL. There is as much alcohol in a can of beer as there is in the average mixed drink or in the average glass of wine, so the alcohol effect of having one beer is just as great.

Senator DODD. How do you explain this high income difference? I happen to know the town you are from. I did not realize where you were from exactly. I have good friends that live in the town of Saratoga, California, and that is like Fairfield County in Connecticut—there is not a lot of low-income housing in Saratoga.

Why is it? Dr. Lapham, maybe you would comment on this. Do physicians treat wealthier patients differently than poorer patients? Obviously, they do in some ways, but I mean in terms of what advice they give them.

Ms. LAPHAM. Yes. Perhaps not so much advice as that they just do not even explore the question of drinking with them. There is often an assumption that an educated person, with a certain income, has a certain amount of knowledge, and since alcohol is something that is a very acceptable social kind of thing in our society, its use and abuse does not get discussed.

I talked with some physicians about this issue this past week while preparing my testimony. One pediatrician said she has a friend who is a lawyer and his wife has a reputation for drinking too much. They have a 16-year-old son that has all of the FAS features, you can just tell by looking at him. But there is no way the pediatrician would say anything. Her comment was that they are a nice family.

Senator Dodd. Rosemary, do you want to comment?

Ms. Tisch. I have a couple of comments that I would like to make on that, just in my personal experience. In recovery, I have gone to our child's pediatrician and he said you are not an alcoholic, I would have known. He just absolutely will not take that as medical fact on my kids because he does not believe it.

My OB, when I was trying to get pregnant, told me to drink wine, to relax so I could get pregnant. The medical community is not seeing it.

The other thing, and I do not have it in front of me so I do not have the facts right, is the recent Gallup poll that was out I believe in our Sunday paper a week ago. If you look at the number of families that drink and then the number of families that report problems (it is done by income levels) the statistics stress that there has to be denial when you go over $40,000 per year. It is just plain your high-income people are denying it.

I think some of it is that the money helps cover it. In our own case, we were able to hire child care for a lot of the time, so some of the money is covering some of that, but it is definitely there, there is no question.

Senator Dodd. Let me ask one more question of all three of you quickly, and then I want to get to my good friend from South Carolina. He has been very patient. He has a deep interest, I might add, in this subject and has offered legislation that I am sure he is going to talk about when this Senator from Connecticut pipes down.

I wonder if you might comment on the public service announcements. What works and what does not work? We heard Joe Califano talk about cartoon programming on Saturday as maybe the better way to reach children. You heard me raise the issue of overloading the school system with too many educational programs. I fear that there are going to be so many messages about what to do and what not to do, that all of those messages will end up being diluted or lost. Joe made a good suggestion on how to focus the message.

I wonder if the three of you might comment on how we might better reach children of alcoholics in terms of letting them know what they can do, where they can go and what sort of help they can expect. What suggestions might you have for them in terms of how to deal with the problem.

Let me begin with you, Rosemary.

Ms. Tisch. Shall I take it first?

Senator Dodd. Yes.

Ms. Tisch. I really would like to see school based programs, but without the labeling on the children. When we started two and a half years ago the school program, we said we are going to go in and we are going to serve children of alcoholics and we are going to do this, this and this. Within the first series of our first ten weeks of being there, we said no, these groups are open to any children in the school, but we know we are after the children of alcoholics. The groups are open to everyone, so there is no stigma involved.

How do we get the kids then? Our school component has three parts. It has a teacher training component. We call it teacher training, it is actually for anyone on the staff, and we require a school to have that before we will ever come on campus. What we do is teach the teachers about chemical dependency, about codependency, and then about the kids.

What we find is at least 50 percent of the teachers have been personally affected by the disease of alcoholism or chemical dependency, so we have all of their denial systems going there before they ever even start working with the kids. So it is very important to do the teacher and the staff training before you ever go on campus.

We also work with parents. We have a night where we come and talk about high-risk situations and what do you do to help your kids. Very few parents come to those, but I think it is still important to have it and then come on campus. Come on campus in classrooms with curriculums, come there also with support groups for children that identify that they need more help. So there are two parts to that.

Senator Dodd. Why do you not have a meeting with the PTA, kind of a separate thing?

Ms. Tisch. We have tried everything and if it is announced that we are coming to talk about alcohol and drugs no one comes. The same goes for the school district. There is another program called Quest, which is a very good program and they have different parenting evenings. They are running about 100 parents a night, one on communication, one on how to teach your kids about growing up sexually. They came to chemical dependency and had 30 parents show up. The parents are not coming out for this. It is really scary because you are talking about your own use, you are not talking about the kids' use. In adolescents we are seeing the same thing, 90, 100 percent of the adolescents in treatment have alcoholic parents and they do not want to hear these things.

So I really look at school systems, but you have got to look at training, training some professionals. I want to add two things, and I mentioned it before. We cannot put the ads on the Saturday morning TV until we have services to provide for those kids.

Senator Dodd. The what?

Ms. Tisch. Service to provide for the kids. That is why the schools are so nice, because we can go ahead and work with the kids. We have done it on one campus without parent permission. It is really scary but we have done it. So with the right legislation, it could be done.

Senator Dodd. But some of the things you did in that camp program, they do not require services—like those little lessons they had about things that children can do.

Ms. Tisch. That is called services to kids.

Senator Dodd. Well, calling the 911 number for an ambulance when you find your mother or father drunk on the floor—that is not hard.

Ms. Tisch. Right. I am talking about the fact that we had the camp and we had to have permission to work with the kids, to teach that.

Senator Dodd. I know that. I am speaking about the programming on Saturday in an instructional way. Commercial programming is also a way of making children aware of some of the things they can do that will be helpful.

Ms. Tisch. Right.

Senator Dodd. Any comments from either of the two of you?

Ms. Lapham. I think this is a problem with many facets and the approach to prevention is going to also need many facets. Certainly, the schools are one facet and the media is another. For prevention of FAS, educating adults, women in particular, is essential. I think more education needs to be done in doctor's offices and in mental health agencies. Perhaps warnings on ads for alcoholic beverages, and on the containers may be effective.

I want to go back to the counselling issue. I am always amazed that FAS specialists and Alcohol and Drug Abuse specialists go their separate ways and seldom even communicate. I recently heard a geneticist speak on the topic of FAS and when somebody raised a question about alcoholism, the genticist said, "Oh, that is not my field, I know nothing about alcohol." I also talked to a mental health therapist providing treatment for college students with alcohol abuse problems and asked her if she ever deals with fetal alcohol effects. Her reply was, "Oh, no, the students are not those kinds of people."

So I think that we have a breach within the alcoholism field that needs to be bridged of professionals who work with alcohol abusing women who are potential mothers and professionals who see the results of ARBD in infants.

Senator Dodd. An excellent point.

Dr. Russell.

Ms. Russell. I agree with what has been said. I am more familiar with programming to get the message about fetal alcohol syndrome across. We found that in New York State, before the New York State Division of Alcoholism and Alcohol Abuse started actually paying to put these messages on prime time, you would see them at 3 a.m. in the morning, so that is one issue.

The other issue is that sometimes even when women have heard these public announcements, they need to have it reinforced by their physicians and by the physicians' nurses. They are a very important part of the whole message. They have the influence on the patient to actually change behavior. There are two aspects to change in behavior. One is to know it and the other is to do it, and somehow doing it seems to be motivated by the physician's message.

Senator Dodd. Well, you are three excellent witnesses and I could carry on with you here for some time. There are a lot of other questions that I have myself, but I have gone longer than I planned. Our distinguished ranking minority member is here. He is former President pro tempore of the Senate, and a person with deep interest in the subject. Senator Thurmond, I apologize for taking as much time as I did.

Do you have any comments or questions?

Senator THURMOND. Thank you very much.

Mr. Chairman, I had an opening statement. I had to go to the White House. It is very brief and I think I will make it now.

Senator DODD. Certainly.

Senator THURMOND. I will ask the Reporter to put it with your opening statement at the beginning and then I want to make a few comments.

Mr. Chairman, there are 28 million children of alcoholics in the United States. Seven million are under the age of 18. One out of every eight Americans is the child of an alcoholic.

The effect of this on children is devastating. They often feel guilty or responsible for parental drinking or drug abuse. This in turn can create long-term problems in adjusting to society as they reach adulthood.

Mr. Chairman, I recently viewed an exhibit of drawings by children of alcoholics sponsored by the Foundation on Children of Alcoholics. I had the pleasure of having Migs Woodside, the founder of this organization and one of our witnesses today, show me this exhibit. From these drawings, it was clear and saddening how devastating alcohol and drugs abuse can impact a family.

Mr. Chairman, Mr. Neal, from South Carolina, is here today and I just want to say a word about him and then make a few more comments.

Mr. Chairman, I also am pleased to welcome Jim Neal, Director of Prevention, Education and Intervention of the South Carolina Commission on Alcohol and Drug Abuse. Mr. Neal has been very involved in developing a statewide student assistance program for students in our schools having problems with drugs and alcohol. I understand that last week the National Association of Student Assistance Programs recognized the program in South Carolina as the most outstanding in the Nation, and I commend them for this fine achievement.

Mr. Neal, I want to say that we are very pleased to have you here today, and I am confident that the committee will benefit from what you have to say.

Mr. Chairman, I also wish to commend you for conducting this hearing on this serious problem. This committee can accomplish a great service just by educating people. These hearings provide an excellent opportunity to do just that. We do not always have to have a particular piece of legislation as a subject of a hearing to raise public awareness. I want to commend the Chairman for recognizing how valuable a committee hearing can be to educate the people.

Now, Mr. Chairman, I want to say this: I was on a plane 2 years ago in which a woman sat across the aisle from me on the plane with a child I guess about two years old. The little child's forehead was badly wrinkled and the child appeared very dull and listless. I am not a doctor. There are eight doctors in my family, but I could judge that that child was born of a mother, because that very day she was drinking on the plane, too, and that child was born of a mother that was a heavy drinker.

In addition to that, she sat there and smoked profusely, with the smoke blowing into the child's face and around until finally I asked her would it not be helpful if she did not smoke so near the child.

I am convinced that every step possible should be taken to educate the people of this Nation, especially the mothers of this Nation on the dangers of alcohol. I did my best to get a labeling bill through the Senate cautioning people about the dangers of alcohol, especially pregnant women. The Senate did not see fit to pass it. The alcohol lobby here was too strong. There is not a stronger lobby in this Nation than the alcohol lobby.

I am convinced that it should be passed yet. Finally, I did get through a provision, we compromised on this, for the HHS to conduct a study, and I am anxious for them to come out with the results of that study, then maybe it will help us to get a labeling bill. In my opinion, if we can have a bill on the dangers of smoking, we ought to have a bill on the dangers of alcohol, which is even much more dangerous. It affects more people and causes more deaths, more automobile wrecks, and more heart rending effects on the people than any one thing I know of, and I just hope that can be done.

Today I do not see a television here. I come in this room every week and incessantly there are television cameras here. There is nothing sensational about this. It is far more important than something sensational. The television would do a great service to our Nation if they had been here today and recorded this program. Here you have got two medical doctors, very able women, and you have another very fine lady, Ms. Tisch, who testified. Their testimony would be valuable to the people of this Nation. If televisions would have run it, they would have done a great service to have carried that testimony, and I am sure other witnesses on the program today likewise.

Sometimes I wonder if we have got our values right. There is nothing more important than the children of this Nation. There is nothing more important than protecting them. They cannot protect themselves. There is nothing more important to the future of our Nation than what we do for these youngsters. And one of the most important things that we can do is to see that their mothers do not drink during pregnancy and to encourage people not to take alcohol, especially where it is so damaging to them. I believe the New England study may have shown how dangerous alcohol is and how much it causes breast cancer.

I have known a number of women who drink and a large portion of them had to have their breasts removed because of breast cancer. I did not know anything about the scientific part of it, but since then the studies which have been carried out, that which has been learned. So there is so much here that the public should get that is good for the public, of benefit to the public. And after this, when you have a program like this, Mr. Chairman, I would suggest you try to get the TVs here and get them to carry these programs, because what you are doing is working with health. The health of people means more than anything else. If you have got health, you have got it all. If you have not got health, you are tremendously handicapped.

So we ought to do everything we can to promote health and nothing will do more than to show the dangers of alcohol. I want to commend you ladies for coming and testifying, and I just wish that everybody in the Nation could have heard your testimony.

Thank you, Mr. Chairman.

Senator DODD. Thank you, Strom, for those kind words as well. For whatever it is worth, we try to get attention. We did have one camera crew here, I do not know where they were from; and we do have a print journalist and others. You are right, we did not find anybody in a bush here. There is less attention for these kinds of things. We will just keep at it, that is all, and I have hopes that somewhere down the road we will get someone to pay some attention to us. Unfortunately, we did not them here this morning, but I thank you for coming. Your deep interest in this subject goes back a long time, so it is important to have your participation as well.

I have more questions I am going to submit to the panel. We are running so far behind here this morning. We have two more panels and I want to get through before lunch. So I am going to ask you to accept some written questions that will be sent to you. If you could just get back to us on those, it will be very, very helpful.

I thank all three of you again for being here today. We really appreciate the fine efforts that you are involved in. We are going to try to make this a more important issue. Your point about doing for this issue what we did for the rubella problem is something I would like to see happen.

I was talking with my staff last evening, Strom, and there are certain statistics about children in this country which are just utterly appalling. You know, we are tied for 20th place in infant mortality worldwide. We are in the bottom of the heap among industrialized nations and children make up the poorest sector of our population.

The fact is we have, as you point out, the 7 million children under the age of 18 and 22 million adult children across the country that are growing up in alcoholic homes. Maybe we ought to have some sort of barometer to set some goals for the country. Americans like goals and they like to compete. Maybe we ought to have something like the CPI for children, indicators of how we are doing on fighting these problems on an annual basis. We ought to know whether we are ahead or behind in trying to eliminate some of these problems. Maybe we should set such goals for the year 2000.

I suspect you might find a lot more people interested if they knew that each year we were lessening the infant mortality rate and improving the lives of children growing up in alcoholic homes. Americans would probably like to be competitive in that sense, if you know what I am addressing here. I was sitting in the office last night with my staff, discussing this idea of setting goals. It occurred to me that maybe if we set some societal goals, we could achieve a lot more over the next few years.

Senator THURMOND. May I ask one question?

Senator DODD. Certainly.

Senator THURMOND. I felt for a long time that it would be helpful if we could get a film made and show it in the schools. It could be portrayed very dramatically, I think, as to the dangers of alcohol and of smoking, too. I would like to get your opinion, of you doctors especially, on that.

Ms. LAPHAM. I think a film or several films would be an excellent way of approaching children of different ages in schools.

Senator Thurmond. Children will watch movies and they are impressed by movies.

Mr. Lawson. Right.

Senator Thurmond. And if you have good actors and good actresses in the movie of that kind, it just impresses me that it would be most helpful.

Mr. Travis. Senator, there is one thing I would like to point out on that, and I think we move kind of addressing it when we said movies, is that one-shot efforts on this does not work. We have got to go in and stay with it on a weekly, monthly, yearly basis. Movies would be wonderful to have with it. There are some good movies out, but we have got to look at comprehensive programs that will address kids from kindergarten on through high school and really be there every week with trained facilitators, teachers to support them.

Senator Thurmond. Is it not a continuous process, though? Should you not start in the lower grades and continue right on through high school?

Mr. Travis. That is right.

Mr. Lawrence. That is right.

Mr. Travis. The average age of beginning use in our county is 11 years old, so we have got to be there before the use.

Senator Denton. What is that?

Mr. Travis. Average age of beginning of use of alcohol and drugs in Santa Clara County is 11 years old.

Senator Denton. The average?

Mr. Travis. The average. So we have got to start in kindergarten to stop it.

Senator Thurmond. I think we have got a tremendous educational problem.

Mr. Travis. One problem——

Senator Thurmond. It is a great challenge here and if somebody can just take the lead and impress the American people and get this done. I cannot imagine a finer service.

Mr. Russell. One problem that we have in showing the dangers of alcoholism in a movie is a credibility problem. Children see their parents drinking, they see their older brothers and sisters, that it is such a part of our culture and our community life that they have difficulty believing the message of the danger that is in the movie.

Senator Denton. It is interesting, we are talking about movies. Strom, I just found out that one of the reasons we have so few TV cameras here today is that Woody Allen is testifying about the colorization of black and white films. That is the big hearing of the day. [Laughter.]

I almost wish I did not know that we were going to have a conflict, but that is where rightly some will be sought.

Senator Thurmond. I guess you saw the story of Mrs. Ford. It was on public television some time ago. Did you all see any of that?

Senator Denton. President Ford's wife.

Mr. Lawrence. Yes.

Mr. Travis. Oh, yes.

Mr. Lawrence. I think one of the things that was pointed out to me just this week is that there are a number of people who are willing to go before the public and talk about their alcoholism now they are recovering. It is a lot more difficult to go before the public and talk about having damaged a child from alcohol. I think you were asking before why we do not have more upper income people talking about it, and I think that is another of the reasons.

Senator THURMOND. It can wreck the family and it can wreck the country if we do not get it under control. And it is the most powerful lobby in the country. It is hard to compete with it. I could not even get a labeling bill through the Senate just to warn people. The alcohol lobby is a powerful one.

Senator DODD. I thank all three of you very, very much.

Our next panel of witnesses, Strom, will focus on the risks faced by adolescents and young adults whose parents have a past or present alcohol or drug abuse problem. Our first witness is Jim Neal, who has already been referred to by Senator Thurmond.

He is the Director of Prevention, Education and Intervention, South Carolina Commission on Alcohol and Drug Abuse, Columbia, South Carolina. He has been in the field of alcohol and drug abuse for 23 years, so he brings some considerable experience to the issue. In addition to the work he does for the State, he teaches a course on alcohol, drugs and crime at the University of South Carolina.

Our second witness is Andrew Klein, Chief Probation Officer, Quincy Division of the Trial Court of Massachusetts, Quincy, Massachusetts. He spent the last 11 years as the Chief Probation Officer in Quincy. Before then, he worked for the Attorney General of Massachusetts, and we are delighted to have his firsthand expertise gathered from his work with juveniles who have come before the court in that city.

Phil Diaz is the Director of the Division of Alcohol and Drug Abuse for Rockland County Mental Health Center, Pomona, New York. He is also a member of the Advisory Board to the Alcohol, Drug Abuse and Mental Health Administration, ADAMHA. He is a founding board member of the National Association of the Children of Alcoholics. He is also co-chair for the New York State Black Hispanic Network on Alcohol and Other Substance Abuse, and the author of "Breaking the Cycle of Addiction, A Parents Guide to Raising Healthy Children."

And last but not least, Ellen Morehouse, Executive Director of Student Assistance Services, White Plains, New York, who has been working with children of alcohol and substance abusing parents for the past 13 years. She is a founding board member of the National Association of Children of Alcoholics, has been widely published and, I might add, was the other voice on that local radio show last night when I called in to talk about this problem for a few minutes. It is a pleasure now to place the face with the voice.

I thank all four of you for being here. Jim Neal, we will begin with you. Again, we welcome you to the Committee. We are running very late and I have one more panel of witnesses. Your prepared statements will be made a part of the record today, and if you would like to paraphrase them so we can get to the questions, you may find it a bit more profitable.

Some of the issues we may have covered already. I think some of the data base has been pretty well established today. In almost all of the statements people have been referring consistently to the numbers. That is very helpful, I might add. We seem to have some uniformity on the numbers. Again, I thank you for being here and your statements will be made a part of the record.

Jim.

STATEMENTS OF JAMES A. NEAL, DIRECTOR, PREVENTION, EDUCATION AND INTERVENTION, SOUTH CAROLINA COMMISSION ON ALCOHOL AND DRUG ABUSE; ANDREW KLEIN, CHIEF PROBATION OFFICER, QUINCY DIVISION OF THE TRIAL COURT OF MASSACHUSETTS; PHIL DIAZ, DIRECTOR, DIVISION OF ALCOHOL AND DRUG ABUSE, ROCKLAND COUNTY MENTAL HEALTH CENTER, POMONA, NY; AND ELLEN MOREHOUSE, EXECUTIVE DIRECTOR, STUDENT ASSISTANCE SERVICES, WHITE PLAINS, NY

Mr. **NEAL**. Thank you, Mr. Chairman, Senator Thurmond. In the interest of time I will move as quickly as I seldom can, as slow as we tend to speak from time to time.

Senator **DODD**. I have seen you move very quickly. I have seen Strom Thurmond move very quickly.

Senator **THURMOND**. We talk slow, but we think fast, do we not?

Mr. **NEAL**. Yes, sir.

[Laughter.]

Mr. **NEAL**. It is an honor for me to be here. I think I represent many of my colleagues who work in the public sector and I also, I am sure, like many of my colleagues, come from a family where alcoholism was prevalent when I was growing up, so I have both a personal and a professional interest.

I would like to talk mostly about programming from the public sector and particularly from my home State. I am employed by the State Commission on Alcohol and Drug Abuse, which is the State agency that is responsible for providing primary prevention, intervention and treatment services in our State.

We contract with 37 county alcohol and drug abuse authorities to provide these services in all of our State's 46 counties, and during the past year this statewide network provided intervention and treatment services to more than 39,000 clients, ranging in age from 12 to 68, in addition more than 308,000 individuals were involved in some type of alcohol and drug education program, excluding media campaigns and public service announcements.

Programming for adolescents is a very high priority for anyone who is working in a public alcohol and drug agency, be it on the State level or the community level. We approach programming from a couple of perspectives, and I just want to briefly mention those.

One is from looking at the indicators of adolescent alcohol and drug use and building primary prevention and intervention and treatment programs to address those indicators of use. I am not going to go into detail about those because of the time, but there are a number of high-risk social/environmental, intrapersonal and behavioral factors that we know are indicators of adolescent alcohol and drug abuse. These are mentioned in detail in the typed statement I am leaving with the Committee.

In addition, we know that children of alcoholics, may also have other factors that will influence their choices around alcohol and drugs or other behavioral problems. Among those are low self-esteem, an external locus of control, conduct disorders, learning disabilities, alcohol and other drug use, certain types of hyperactivity and suicidal tendencies.

It is also important in doing prevention programming to recognize that not all children who come from families where alcoholism is present or all adolescents who come from high-risk social environments are going to have problems with alcohol or other drugs.

In particular, we know that children of alcoholics who do not develop serious coping problems during adolescence have certain characteristics that are present. Among these are plenty of attention from the primary caretaker during infancy, the absence of conflict between parents during the first 2 years of life, a temperament that elicits positive attention from caretakers, average intelligence and adequate written and verbal communication skills, an achievement orientation, a responsible caring attitude, a positive self concept, a more internal locus control and a belief in self-help.

So, from the perspective of developing primary prevention programs, it is important not only to look at the indicators of alcohol and other drug use, but it is also important to look at some of those things that are present among many adolescents that seem to be protective factors, so that they can be enhanced at the same time as the indicators for high risk are being addressed.

Some of the programming that we have been doing to address adolescents in general and children of alcoholics specifically has been to develop a list of recommended alcohol and other drug education curriculum to be used by our schools. South Carolina does not have statewide mandated curricula. We are very independent throughout our State. Our school districts are able to choose the type of programs that they want to use.

So what we have done in conjunction with our State Department of Education has been to develop a recommended list of curriculum that feature activities as part of those strategies that can address these early indicators of adolescent alcohol and drug use, as well as the characteristics of children of alcoholics.

In addition to developing the list and making the recommendations to all of our school districts, we provide funding for implementation, and teacher training. We are in the process of encouraging all of our graduate schools throughout the State, particularly those that are doing teacher training, to have as part of their required curriculum a course on alcohol and drug abuse.

A second item that we are doing statewide that we are very enthusiastic about is our Teen Institute for Alcohol and Drug Abuse Prevention. This is a week-long activity that teams of youth, with an adult advisor, attend. While they are there during the week, they develop an action plan for a peer prevention program that they are going to do throughout the year within their schools or within their communities.

The important thing about this type of activity is having peers doing primary prevention with their peers, rather than adults always bringing it into the schools. Although we think that the immediate impact that these teems have upon peers of their own age is important the impact that they are having on younger students, by presenting models that are more worthy of emulation hence increasing the opportunities, skills, and rewards for younger students in participating in non-drug activities will be the long range benefit of this approach.

A third area that we have concentrated our primary prevention programs on has been youth and group homes. I would suggest, Mr. Chairman, that this is one of the populations of children of alcoholics that is currently being neglected in our programming nationwide. In our State, we have a substantial number of children who are in foster homes and in group homes. We have done an informal survey with our group homes and have found the number of adolescents who are in group homes who are children of alcoholics range from 60 to 80 percent.

No one at this point that we know of—and we have been searching nationwide, has developed prevention programs for children of alcoholics within group homes. Hence we have launched a demonstration project in our State to develop prevention activities and strategies for children of alcoholics who are in group homes.

In addition to those who are in group homes, there is another population of children of alcoholics that are being neglected, and those are adolescents who are within schools or institutions for the deaf and blind. Persons who have visual and hearing handicaps are particularly at risk for alcohol and other drug abuse. This risk is increased if they are the child of an alcoholic.

We have launched a demonstration project with our State School for the Deaf and Blind to develop primary prevention materials first for those who have hearing impairments, and secondly for those who have vision impairments. We are very interested in trying to network this effort nationwide.

Our major effort within the schools has been our School Intervention Program which we call ScIP for short, is our statewide student assistance program. We are very proud of it. We started in 1978 with a demonstration project in five counties. We completed statewide implementation in 1984.

It serves all of our 92 school districts, from grades 7 through 12. The ScIP program provides the schools with an alternative to traditional sanctions when the school discovers an adolescent who is violating the rules or regulations regarding alcohol or other drugs or who may be identified as a high risk for alcohol or other drug abuse because of certain behavioral indicators.

The program has some standard components. Among those is policy development by the schools which we find to be extremely critical. If schools do not have a policy on how they are going to handle student alcohol and drug use as well as alcohol and drug use on the part of their faculty, then we do not find the program to be as effective.

The student assistance program, as we approach it, is built somewhat on the basis of coercion. The student is in essence told by the schools you have a choice at this point because you have violated one of our rules. You have a choice of traditional sanctions or entering the program.

So policy development is our first and major component. Other components are teacher training, particularly training of counsellors within schools on adolescent alcohol and drug use, how to recognize adolescent alcohol and drug use, and how to make referrals.

Referrals are made to our ScIP intervention specialists who are credentialed by the State, and provide services ranging anywhere from education and treatment to case management and follow-up.

Last year, we saw over 5,000 students entering the ScIP program. Of this number, approximately 65 percent were children of alcoholics.

In summary, there are a number of areas that we feel there is a need to focus on in the future that we hope will benefit South Carolina as a result of these hearings and others. Among those are training of staff of other Health and Human Service agencies in the identification and treatment of children of alcoholics, the development of intervention programs within the juvenile justice system, and the development of intervention programs within businesses that employ adolescents.

We would also like to see more support networks for children of alcoholics. Although our ScIP program has been successful at identification and getting adolescents into services, we are not as successful in providing the support networks that are needed once they are within intervention or treatment programs. We are also very interested in seeing the expansion of demonstration projects that deal with adolescent children of alcoholics who are within group homes.

Thank you very much.

[The prepared statement of Mr. Neal follows:]

SUBCOMMITTEE ON CHILDREN, FAMILIES, DRUGS AND ALCOHOLISM
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE

Statement by
James A. Neal, Director
Prevention, Education and Intervention
South Carolina Commission on Alcohol and Drug Abuse
Columbia, South Carolina
May 12, 1987

The South Carolina Commission on Alcohol and Drug Abuse (SCCADA) is the state agency responsible for developing and providing alcohol and other drug abuse primary prevention, intervention and treatment services to all of the state's residents.

To meet this goal, SCCADA contracts with 37 county alcohol and drug abuse authorities to provide these services in all of the state's 46 counties. During this past year, this statewide network provided intervention and treatment services to more than 39,000 individuals ranging in age from 12 to 68. In addition, more than 330,000 individuals were involved in some type of alcohol and drug education program excluding media campaigns (Appendix A).

SCCADA attempts to design programs that target specific high-risk populations as well as the general public.

Programming designed to prevent adolescent alcohol and drug use, to identify adolescents who are at high risk, and to refer those who are experiencing problems at an early stage in order to ensure that they receive the appropriate education or treatment service is one of SCCADA's major priorities. The world of the adolescent is one of constant change. Factors in this social environment that are associated with alcohol and other drug use include family or peer approval or tolerance, family or peers as real or perceived role models, pressure from family or peers to use, greater influence by peers than parents, greater reliance on peers than parents, absence of closeness to parents, low educational aspirations for the children by the parents, lack of parental involvement in the child's activities, weak parental controls and discipline, and easy access to alcohol and other drugs. These social/environmental factors are interrelated with intrapersonal factors that are associated with alcohol and other drug use such as greater value on independence, lower value on achievement, tolerance of deviant behavior, lower religiousity, expectations of failure, apathy, high levels of distress and lower conformity to social conventions.

In addition, certain behavioral factors regularly associated with adolescent use of a particular drug include use of alcohol and other drugs, various forms of delinquency, sexual activity and declining academic performance. (Murray and Perry, 1985)

In summary, it appears that high-risk social/environmental, intrapersonal and behavioral factors are the most important indicators of alcohol and other drug use by adolescents. Obviously, not all adolescents in high-risk environments choose to experiment with or use alcohol and other drugs. Hence, intrapersonal and behavioral factors may be critical in influencing the adolescent's response to the environment through the value placed on conventional goals and activities and through the life skills that encourage him or her to participate in meaningful non-drug alternatives.

Obviously, adolescents are extremely vulnerable to alcohol and other drug use. Consequently, adolescents who are raised in homes where parental alcoholism is present represent the highest risk subpopulation of adolescents in this country. Studies on the behavior and development of children of alcoholics have found that in addition to the above factors, significant proportions of these adolescents have low self-esteem, external locus of control, conduct disorders, learning disabilities, records of repeated delinquency, alcohol and other drug use and suicidal tendencies. (Werner, 1986) Also, certain types of hyperactivity have been connected with this vulnerability. (Tarter, 1985)

As a result, primary prevention programs designed to address the factors that influence adolescent alcohol and other drug use must also take into account these additional characteristics of the children of alcoholics who do not develop serious coping problems during adolescence. Among these are: plenty of attention from the primary caretaker during infancy; the absence of conflict between parents during the first two years of life; a temperament that elicits positive attention from caretakers; average intelligence and adequate written and verbal communication skills; an achievement orientation; a responsible, caring attitude; a positive self-concept; a more internal locus of control; and belief in self-help. (Werner, 1986)

SCCADA has endeavored to develop primary prevention strategies for this high-risk subpopulation of adolescents through the following program initiatives.

1. A recommended list of alcohol and drug education curricula for schools has been developed in conjunction with the South Carolina Department of Education (SDE). This list includes curricula that feature activities designed to address these characteristics. The list is updated annually and distributed statewide to all school districts. In addition, SCCADA and the SDE assist school districts through funding and training of teachers in the delivery of the programs.

2. The South Carolina Teen Institute for Alcohol and Drug Abuse Prevention is a statewide activity that trains teams of youth enrolled in grades 9 through 12 and an adult advisor in peer prevention activities that can be implemented in schools and communities. Although Teen Institute teams have an impact on their peers, the long range impact may be on youth who are just entering adolescence by providing them with involvement and interaction with older adolescents whose behavior is "worthy" of emulation and increasing the opportunities, skills and rewards for such participation. (Hawkins, 1985) Currently, we train 80 teams per year (320 youth and 80 adult advisors) impacting on approximately 50 percent of the state's high schools.

3. Youth in residential and group homes have been targeted by SCCADA for special programming because of the unusually high percentage of these adolescents who are children of alcoholics (60 to 80 percent

according to informal surveys conducted by SCCADA). For the past two years, a demonstration project at two residential homes serving approximately 300 youth annually has been developing prevention materials and strategies for this population. In addition, a special demonstration project at the state's school for the deaf and blind is developing materials for this handicapped population.

4. Alcohol and drug abuse programs also provide general prevention and education services to adolescents. These services are provided to churches, schools, clubs, teen centers and recreation programs and include alcohol and other drug abuse information, community organization, alternatives to alcohol and other drug use, awareness programming, "Just Say No" programs, and a variety of other innovative approaches.

The School Intervention Program (ScIP) is SCCADA's major intervention program designed for adolescent children of alcoholics and other troubled adolescents. Implemented in 1978 as a demonstration project in five counties, this student assistance program was expanded statewide in 1984 and offers services to students enrolled in grades 7 through 12 in all the state's 92 school districts. ScIP provides schools with an alternative to traditionally sanctions for students who violate rules and regulations regarding alcohol and drug use or who may be identified as high risk for alcohol and other drug abuse because of other behavioral indicators (Appendix B). The program includes the following standard components: policy development by schools; training of teachers and staff on adolescent alcohol and other drug use; and student referral to credentialed ScIP intervention specialists who assess the extent of the students' problems and refer them to services ranging from education to treatment provided by credentialed personnel. The program also provides case management and follow-up services for each student. Evaluation of ScIP has shown positive results for schools as demonstrated through a reduction in behavioral problems and an increase in grades. For students, the program has resulted in reduced absences, disciplinary encounters with the school and alcohol and drug related problems. During the past year, more than 5,000 students were referred to ScIP. Of this number, approximately 65 percent are children of alcoholics who require specialized programming to meet their unique needs.

In the future, SCCADA hope to continue these primary prevention and intervention programs for adolescent children of alcoholics and other youth and expand our efforts to include: 1) training of staff of other health and human service agencies in the identification and treatment of children of alcoholics; 2) the development of assessment and intervention programs within the juvenile justice system and with businesses that employ adolescents; 3) the development of support networks for children of alcoholics; and 4) expansion of the demonstration projects for adolescents in group homes.

JAN/6640.2(bma)(2)

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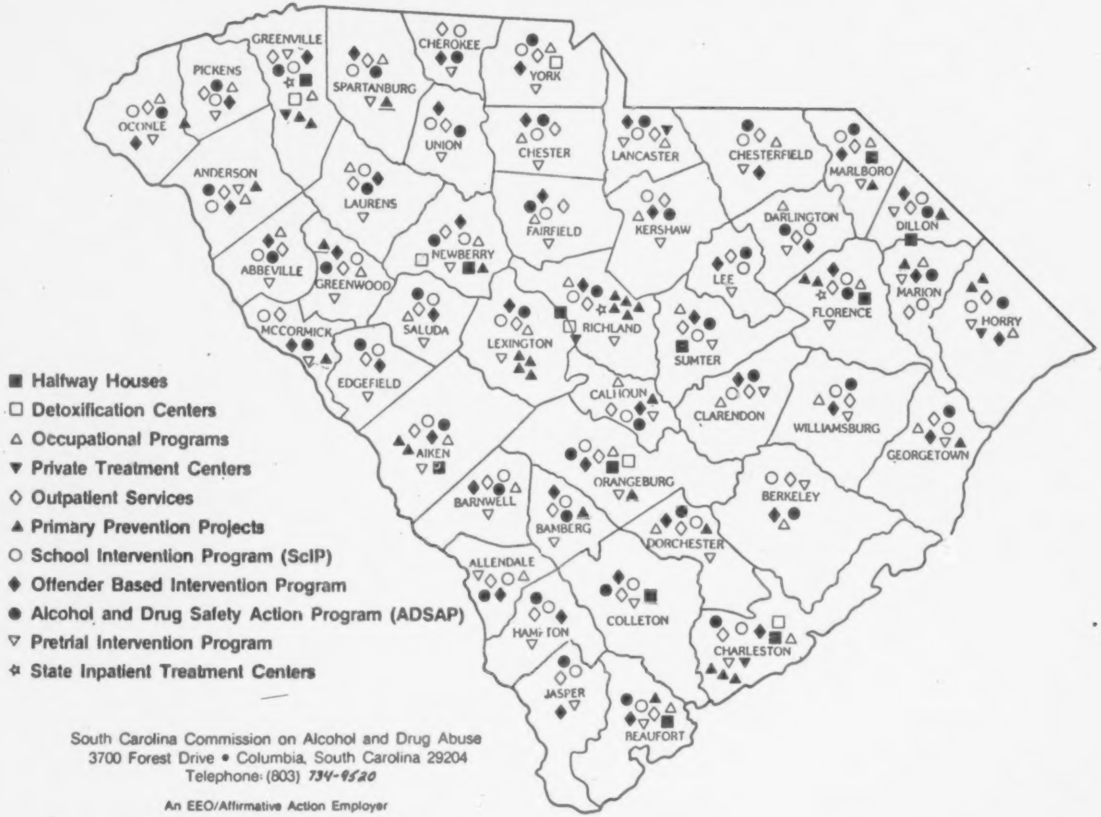
Appendix A

South Carolina Network of Alcohol and Drug Abuse Services


GREENVILLE
PICKENS
OCONEE
SPARTANBURG
CHEROKEE
YORK
UNION
CHESTER
LANCASTER
CHESTERFIELD
MARLBORO
DILLON
ANDERSON
LAURENS
FAIRFIELD
KERSHAW
DARLINGTON
MARION
HORRY
ABBEVILLE
GREENWOOD
NEWBERRY
LEE
FLORENCE
MCCORMICK
SALUDA
LEXINGTON
RICHLAND
SUMTER
EDGEFIELD
CALHOUN
CLARENDON
WILLIAMSBURG
GEORGETOWN
AIKEN
ORANGEBURG
BERKELEY
BARNWELL
BAMBERG
DORCHESTER
ALLENDALE
COLLETON
HAMPTON
CHARLESTON
JASPER
BEAUFORT

- ■ Halfway Houses
- ☐ Detoxification Centers
- △ Occupational Programs
- ▼ Private Treatment Centers
- ◇ Outpatient Services
- ▲ Primary Prevention Projects
- ○ School Intervention Program (SciP)
- ◆ Offender Based Intervention Program
- ● Alcohol and Drug Safety Action Program (ADSAP)
- ▽ Pretrial Intervention Program
- ✡ State Inpatient Treatment Centers

South Carolina Commission on Alcohol and Drug Abuse
3700 Forest Drive • Columbia, South Carolina 29204
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Appendix B

ADOLESCENT RISK PROFILE

	Yes	No
I. Peer Involvement with Drugs (Relationships) - This is the strongest predictor of all groups of predictors.		
A. Strong Peer Models Promoting Use	___	___
B. Perceived Peer Group Support for Drug Use	___	___
C. Greater Orientation toward Peers than Family	___	___
II. Family Problems (Relationships)		
A. Parental Alcohol and Drug Abuse	___	___
B. Poor Discipline	___	___
C. Over Involvement of One Parent and Under Involvement of the Other	___	___
D. Low Educational Expectations of the Child	___	___
III. School Problems (Resources)		
A. Poor Grades	___	___
B. Low Educational Expectations (i.e., intention to drop out of school)	___	___
C. High IQ Coupled with Low Achievement	___	___
D. Low Commitment to School (i.e., class cutting and absenteeism)	___	___
IV. Antisocial Behavior (Readiness/Rationality)		
A. Delinquency	___	___
B. Sexual Activity	___	___
C. Marijuana Use	___	___
D. Alcohol Use	___	___
Each of these tends to predict the other ones.		
E. Shyness or aggressiveness in elementary school	___	___
F. Rebelliousness predicts experimentation	___	___
G. Hyperactivity	___	___
V. Lifestyle (Resources)		
A. Cigarette Smoking	___	___
B. Poor Stress Management	___	___
C. Poor Diet/Nutrition	___	___
D. Lack of Exercise	___	___
E. Risk Taking Behavior	___	___
F. Boys - Party Use (to have a good time)	___	___
Girls - Functional Use (to relax, energize or deal with pain)	___	___
G. Boys Maturing Late	___	___
H. Girls Maturing Early	___	___
VI. Non Conventionality - Attitudes, Beliefs and Personality (Readiness) - This is a relatively weak predictor.		
A. Non Conformity to Traditional Values	___	___
B. Low Involvement with Church	___	___
C. Resistance to Authority	___	___
D. Independence	___	___
VII. Use		
A. Currently Using (How much?)	___	___
B. Reasons for Use (What does it mean to client?)	___	___
C. Substance of Choice	___	___
D. How Often Does Client Use	___	___
E. Patterns of Use	___	___
F. Early Onset Age of Use	___	___
G. How is it Financed	___	___
H. Intentions to Use	___	___

___ Primary ___ Secondary ___ Reactive

Sources:

Hawkins, D.; Lisher, D.; and Catalaro, R. Childhood Predictors and the Prevention of Adolescent Substance Abuse: Etiology of Drug Abuse: Implications for Prevention, NIDA Research Monograph, 56, 1985.

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Senator DODD. Mr. Klein.

Mr. KLEIN. Thank you, Senator Dodd and Senator Thurmond.

When I left State government to work in the courts, I had a naive idea that I was going to find criminals. I was looking for people that I saw on Kojak. This was back in 1975, before Hill Street Blues, before TV became more realistic.

But what I found were not criminals and bad people doing bad things; I found basically the adolescent victims of alcoholism and drug abuse. I found equally as true a court system and a juvenile and adult correctional system which was totally ill-equipped to deal with this problem.

People criticize courts and say they do not work and they are right, but it is not because courts and judges are too lenient or too draconian in their sentencing. It is because they are too ignorant and what they are too ignorant about is alcoholism. Rather than give a lot of statistics, which have been given, I just want to share with you one or two cases that illustrate how court cases are just awash in alcoholism. No matter how they come into court, they proceed along like a Greek tragedy.

Take the case of the Roach family. Mr. and Mrs. Roach split up when their two children, a son and a daughter, were very young. The daughter was an infant and the son was a couple of years older. Mrs. Roach raised the children alone, receiving sporadic child support from Mr. Roach, who had gone off and remarried and concentrated his energies on his second family.

Mrs. Roach was the daughter of an alcoholic and she became an alcoholic herself, drinking progressively during this period. Her children did not come to the court's attention until her alcoholism finally reached the point where she would pass out with no food in the house. The neighbors would eventually call the police and eventually the police got in touch with the welfare department who brought the children to court for something called a Care and Protection Petition.

After a lot of hearings, the court awarded temporary custody to the welfare department and the children were placed in foster care, where they would remain on and off for the next dozen years.

Massachusetts, like any State, has a severe crisis in finding adequate foster care. There is especially no training to foster care parents in dealing with sons and daughters of alcoholics, and so usually the problems get worse and that is exactly what happened in this case.

Also, the mother at times would rally and "say no" to alcohol—which is very easy to do, it is just hard to stop drinking it—and she would come into the court and she would cry in front of the various judges and the children would come back home until she was incapacitated again and then they would go back through the revolving door.

During this period, she did not have a steady judge, so some judges were very knowledgeable in alcoholism and some more typically knew nothing about it. At any rate, things were progressing along that way until the son finally came to the court as a result of stealing a car. He also began at this time stealing from his foster parents. Consequently, he unlike his sister who remained pretty much in foster care, began to spend more and more time with his mother. He became very adept at caring for his mother. She was passing out regularly now and he would hide that fact and he would lie to the welfare officials visiting, et cetera, et cetera.

He also, however, would occasionally burst out in a rage when his mother was drunk and he would physically assault her. During this period, he was living off his mother every time the support checks came from his father, he would beat up his mother, who was drunk, and take the money.

He also began to get into more and more trouble with law enforcement and came into court for breaking and entering, possession of drugs. He was now drug addicted and using alcohol himself. He eventually went through the juvenile court system and ended up in juvenile corrections for a short period of time before he was released at age 17 (he was legally an adult in Massachusetts at 17). He went back to his mother.

He committed his first adult crime, assault and battery with a dangerous weapon, when he pushed his mother down the basement stairs. She was drunk. I believe he broke her leg and he locked her there until she sobered up. She followed through with the prosecution, which she had never done before. He was ultimately—this was his first adult charge—not sent to jail. He was sent to a residential program in Vermont for drug addicted and alcoholic youth, and he did extremely well there.

It turns out, although he had not gone to school during the turmoil of his childhood, he was an exceptionally intelligent and bright child and he did very well in the program. However, the mother repeatedly called him and begged him to come home to care for her, which he eventually did, running away from the facility.

To make a long story short, he got into more trouble, living on and off with the mother. The mother at one point, as a result of a charge brought against her for procuring liquor for a minor and contributing to delinquency of a minor, her own son or daughter, was forced into treatment and she did maintain sobriety for about a year but then went back to drinking.

Right now, she is living in a house which is currently being condemned for lack of upkeep. She probably has brain damage from her alcoholism. She looks to be about 90, although I think she is only in her early 40s. The State continues to pay full-time foster care for the daughter, even though she spends a lot of time with her mother. But when she cannot stand her mother's drinking, she has a haven to go back to, which she does.

The son has been in adult prison several times, the first time for leaving the residential program in Vermont, which he was not supposed to do; the second time for various assault and batteries, various malicious damage and assorted crimes like that.

He currently has left our jurisdiction and he is engaging in prostitution and panhandling in Boston. He is, I am told, constantly on drugs or alcohol. That case—I guess we do not have time to go into too many others—is not a typical case in that the crime patterns differ, but it was very common to many of our cases, in fact a majority of our cases. like most of our cases it is awash in alcoholism.

The daughter, incidentally, does not drink. She is a teetotaler, but she has been as damaged by this as her brother in terms of the alcoholism in which they were raised.

We estimate that about 80 percent of our cases brought in for care and protection with hearings to see whether the parents are fit to care for their kids, 80 percent of those parents, either one or both, are alcoholics or drug dependent. About 75 percent of our children brought in for need of services have alcoholic parents. Recently we have done a prediction model to find out which juveniles are most likely to recidivate, and we found that those cases judged to be maximum risk for recidivism, which is about 25 percent of our caseload, every single one of them had an alcoholic parent or parents. Our findings are very equivalent to a Rand study where it measured garden variety felons in prisons versus what they call "violent predators" Rand found that the difference was the alcoholism and drug addiction of the latter.

So we found, as I said before, the courts awash in alcoholism and very ill equipped to handle it, as are social workers, as are foster parents, as are correctional agencies. Additionally there is a problem with the court involved youth that the wrong party is on probation. It is often the parents who refuse to get help or refuse to recognize that there is a problem and, as in the case we mentioned, are very adept at sabotaging the child's treatment.

I think if I conclude with just a few things that are needed, it is that we have got to teach courts and corrections the central role of alcoholism in crime. As somebody mentioned, medical doctors are only given an hour in the standard curriculum on alcoholism, even though it is such a problem. I doubt if judges even receive that much.

We also have to focus on long-term, forced, mandatory, behaviorally specific treatment of these children in families wherever possible. The whole concept of children or persons in need of treatment, the so-called CHINS or PINS laws, has to be changed to "families in need of services," because it is very hard to treat the child in isolation of the family.

One of the problems we also have in terms of treatment is the whole movement to HMO insurance. The HMOs are very reluctant to provide insurance money for alcohol treatment, and that is a block to treatment.

I think another big problem we face is the overall and overpowering cultural environment which not only condones but promotes drinking, particularly for young people. The Say No to Drugs campaign is a problem. I have many parents who come to me, who are probably alcoholics themselves, whose kids have liver damage at age 13 and 14, who have done horrendous things, and the first thing the parents will say is "Thank God they are not on drugs." These are kids that are on alcohol. And I think the trouble with those campaigns is they note drugs, and if we do not make it clear that alcohol is the most prevalent, common and dangerous drug, you set up that rationalization system, I am okay or my child is okay because they are only on alcohol, they are only drinking beer. And I think what we have got to do is change the whole cultural environment which makes kids think that life is like a beer commercial.

A 14-year-old leaves his probation officer and you say, "Johnny, what are you going to do this weekend?" and he will tell you, "Well, weekends are made for Michelob," and they are going to mean that. Within that environment, you have to take a very, very tough stand and I think education is the beginning and it is certainly needed, especially among judges who can be good gatekeepers against incipient alcoholism. Judges can then insist that other social services, foster care systems, and so on also recognize and treat the problem of alcoholism.

[The prepared statement of Mr. Klein follows:]

ADOLESCENT CHILDREN OF ALCOHOLICS IN THE CRIMINAL JUSTICE SYSTEM

Andrew R. Klein
Chief Probation Officer
Quincy Division, Trial Court of Massachusetts
5/12/87

Case * 1: Roach Family

Mr. and Mrs. Roach split up when their two children, a son and a daughter, were very young, the daughter a mere infant and the son only two years older. Mrs. Roach raised the children alone, receiving sporatic child support from Mr. Roach who had remarried shortly after leaving her and begun a second family.

Mrs. Roach was the daughter of alcoholic parents and began abusing alcohol herself. She and her children did not come to the court's attention until her alcoholism had rendered her unable to care for her children. Apparently alerted by neighbors, police came to her home repeatedly to find Mrs. Roach passed out with no food in the house for the children. Eventually, the state welfare agency was notified and subsequently brought the case to court. On a temporary basis, the court awarded custody to the Department and the children were farmed out to separate foster families. For the next ten years the children went back and forth between foster care and their own home with their mother.

The mother would rally, remain sober for short periods and beg the Department to allow her children to come home. She would plead tearfully before the judge for her family's reunion. She would also contact her children at their foster homes and urge them to run away home. The children would come home until a drinking binge by Mrs. Roach or a new court order would prompt their removal. Court orders were not consistent as different judges heard the case from time to time, some more willing to trust Mrs. Roach's promises than others already burnt in the past. Meanwhile, the child became very defensive and protective of their mother and increasing hostile toward their foster placements, particularly the boy.

The son first came to the attention of the police when he was caught stealing a car. He also began to steal money from his foster parents at this time. Consequently, unlike his sister who remained in foster care, he began to spend more and more time at his mother's house. He became adept at caring for her. She was now passing out more and more regularly from excessive drinking. Occassionally, however, he would turn on her when she was drunk and physically assault her. As a teenager, his mother reported that he regularly beat her up and took the support money received from his father, but she would not testify to this. During this period, he began to amass more charges and convictions for possession of drugs, several larcenies, another car theft and finally one Breaking and Entering in the Night Time with Intent to Commit a Felony. He was eventually committed to the state's juvenile corrections department but spent only a short time in secure placement as he shortly reached his seventeenth birthday and was paroled home as was that agency's policy. The Department does not like to keep seventeen olds in its facilities. Now seventeen, he was legally an adult in Massachusetts.

He committed his first adult crime shortly thereafter, an Unarmed Robbery, followed quickly by an Assault and Battery with a Dangerous Weapon case. The latter case again involved his mother. He pushed her down the basement stairs and left her there until she sobered up. He was brought back to court. Under court order, his probation officer arranged for placement at a residential program in Vermont for chemically dependent youths in lieu of incarceration.

The boy did extremely well at the program, proving to be exceptionally intelligent. The boy, however, left the program, running away as a result of his mother's repeated begging over the telephone. She told him that she needed him to care for her. He returned home to help. Mrs. Roche did not tell court officials that her son had come home until once again he assaulted her, this time hitting her on the head with a lamp. Although she pressed charges against him, she later refused to testify.

The intervening years brought more of the same. The court was able to persuade Mrs. Roche, herself, to enter residential alcohol treatment herself at one point as a result of charges brought against her for procuring alcohol for a minor and contributing to the deliquency of a minor, in both cases her son. She maintained sobriety for approximately a year or so, but went back to drinking.

Mrs. Roach is currently living in her house which has recently been condemned for lack of up-keep. She probably has brain damaged from her alcoholism and looks to be ninety, although she is only in her early forties. The State continues to pay for full time foster care for the daughter eventhough she spends many nights with her mother. The arrangement accommodates her desire to be with her mother but also allows her the alternative of leaving her mother's home at any time when she cannot cope with her mother's drunkeness. The daughter does not drink.

The son has been jailed several times since. He was incarcerated for leaving the Vermont residential program. Upon release he was convicted of Malicious Damage to Personal Property, Assault and Battery with a Dangerous Weapon and operating a car after license suspension. He has currently left the city inwhich he grew up for downtown Boston where, we are told, he engages in prostitution, panhandling and the like. He is usually under the influence of alcohol or available street drugs.

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Case * 2: Bagelli

Rick Bagelli is also the son of an alcoholic. His girlfriend, Anna, is the granddaughter of an alcoholic. Her mother too may be an alcoholic. Both Rick and Anna came to the court's attention when they were teenagers, Rick 14 and Anna 12. At that age, Rick was first placed on probation for a series of misdemeanors, committed while he was under the influence of alcohol. They included a Robbery in 1977, an Attempted Larceny, Larceny of a Motor Vehicle, Leaving the Scene After an Accident, and an Assault and Battery on a Police Officer in 1978. The next year he was convicted of Disorderly Conduct and an Attempted Burglary. When he wasn't in trouble or in court, Rick was with Anna.

By the time he was sixteen, Rick was on a warrant. He had failed to cooperate with his court ordered mandatory drug and alcohol treatment. He had also left or been kicked out of his family home. His whereabouts were unknown. As came out later, he was living in Anna's mother's basement where Anna's mother supplied him with food and money. He used the money for alcohol.

At about that time, it was learned that Anna was pregnant. She was now 14. It came out that the father was either Rick or her own grandfather. As it subsequently came out, her grandfather had been having sex with her over several years. When the grandfather became drunk he would sexually assault his granddaughter. Rick was told of the grandfather's attacks on Anna by either Anna or her mother. Shortly thereafter on a late weekday afternoon, Rick called his probation officer and rambled on about suicide. He announced he was going to drink himself to death. He was already quite drunk and would not reveal where he was. The next day he was before the court again. Four hours after the phone call to probation, he confronted the granfather and repeatedly stabbed him with Anna's mother's kitchen knife, killing him.

At first the prosecutor moved to have him tried as an adult and sent to state prison eventhough he was only 16. However when the details of the story came out, the prosecutor lost enthusiasm and Rick was finally committed to the juvenile corrections agency. He spent a year or so in a locked juvenile

facility. Anna's mother was charged with being an accessory, she had driven the boy to the scene of the crime, harbored him while he was a fugitive and supplied him with liquor. She was subsequently acquitted.

Five years later, Rick has come before the adult court for two drunk driving charges, Operating an Uninsured Motor Vehicle, Assault and Battery on a Police Officer and five counts of Leaving the Scene After an Accident, as well as criminal violations of civil restraining orders taken out by Anna with whom he still lives intermittently and, occassionally, physically abuses when drunk.

Anna's baby was taken away at birth by the Welfare Department under court orders that found her an unfit mother. Subsequently the state's Supreme Court returned the child ruling that the court had not given the mother adequate time to prove whether or not she was a fit mother. Returned, the child was severely neglected and eventually retaken permanently. Anna was able to care for herself little more than she was her child. She became addicted to drugs, drifted into petty crime, lived on and off with Rick. Her whereabouts are presently unknown.

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These are but two examples of cases of adolescent children of alcoholics we see every day in court. They come into court as the subject of Care and Protection proceedings, or charged as status offenders, ie runaways, truants, stubborn or wayward children, or under arrest for crimes ranging from vandalism to murder. No two cases are identical in court but certain similarlities stand out.

80% of all care and protection cases, cases where parents or guardians are charges with physical or sexual abuse or neglect of their children, brought to the Quincy Court involve an alcoholic or addicted parent. Also, whatever the activity that brought the case to court, it had been occuring on the average for four years prior to court involvement.

The same figure, more than three quarters of children brought to the court as status offenders, come from families with one or both parents suffering from alcohol or drug addiction. Although the average age of children before the court for status offenses is only 15, more than one half are found to have alcohol or drug abuse problems themselves. By problems we are talking about severe abuse, including liver damage from excessive drinking, physical addiction or inability to refrain from inhaling toxic vapors.

Although we have not made studies of it, the rate of addiction and alcoholism among parents of adolescents before the court for delinquent or criminal acts is also extremely high as is the drug addiction and alcoholism of the children themselves Of those juveniles rated to be maximum risk for recidivism, those who share characteristics of juveniles who become adult career criminals, almost 100% have at least one actively alcoholic or drug addicted parent at the time of their court appearance.

Although one would think that sons and daughters of alocholics would be the last to repeat their parents' behavior, studies document the reverse. They are more likley to repeat this abusive behavior. They are also more likely to be teatotalers. They are less likely to be social drinkers.

Sober or drunk, drug addicted or not, the adolescent children of drug and/or alcohol abusers are extremely difficult to treat in any context. On the one hand, as any line probation officer will tell you, it is extremely difficult to convince a child that his or her drug or alcohol use is excessive or wrong if he or she sees parents exhibit that same or worse behavior at home. On the other hand, it is extremely difficult to expect a nonabusing son or daughter to cope successfully with abusing parents without acting out themselves.

Usually we are forced to try to deal with the child and his or her problems apart from his or her parents. It is obviously difficult to do this. Frequently, the child proves quite amenable to treatment and good conduct in isolation. The problems begin again when the child gets re-embroiled in his or her family. Also, alcoholic or drug addicted parents often sabotage a child's treatment or good conduct, subconsciously having a stake in being able to blame the family's chaos and dysfunction on the child rather than looking closer at themselves.

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Although many experts have written of the devastating consequences of growing up in an alcoholic home, perhaps no one has expressed the situation more succinctly than Dr. George Valliant in his book, THE NATURAL HISTORY OF ALCOHOLISM. He writes: "Outside of residence in a concentration camp, there are few experiences that make one the recipient of as much sadism as does being a close family member of an alcoholic."

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Case * 3: Smiths

The Smith's two teenage daughters were brought to court by their distraught parents who had lost control. Both girls, one 13 and another 14 and 1/2, were running away from home, staying out all night partying and drinking and skipping school. The problems began, apparently, when the mother went to the hospital for an hysterectomy. The Smith's asked the court to declare the children in need of services and get them treatment for their problems.

Mr. Smith presented himself as a solid citizen. He had a full time job and was a faithful officer of the ELKS. He was also an alcoholic. His wife was the daughter of an alcoholic. Although she did not drink, she was unable or unwilling to note the danger signs in her husband's progressive drinking.

Mr. Smith's daughters disclosed their father's problem to the court. Experts also suggested that Mr. Smith may had made sexual advances to his daughters when inebriated but the daughters would not confirm this. When confronted with her husband's alcoholism, Mrs. Smith disclosed a pattern of increasing alcohol abuse on her husband's part. Mr. Smith denied any problem.

The Judge, uniquely knowledgeable about the disease of alcoholism, confronted Mr. Smith, informing him that unless he immediately did something about his drinking the court would not proceed with the child service petititon and, instead, order

a parental fitness hearing.

Mr. Smith entered a residential alcohol treatment within the week. His insurance covered the costs. He now attends Alcoholics Anonymous faithfully and has been sober one year. After a year of treatment, both daughters are doing much better. One is presently in a half way house. Neither have gotten into trouble with the law, pregnant, or expelled from school.

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Case *4: Cains

Jimmy Cains was brought to court at age 15 for vandalism and malicious destruction or property, acts not taken very seriously by a busy urban juvenile court. However, the chronicity of the repeated acts finally convinced court authorities to pay attention to Jimmy.

Probation investigation found that Jimmy had transformed from an A and B student to one on the verge of flunking. He had also changed peer groups for the worse, hanging out with many teens already on probation. Probation also discovered that Jimmy's father was a binge drinker. His last binge had lasted many months, ruining his CPA business, placing the family in tremendous debt.

Jimmy was ordered to attend Alateen, a support group for teenage sons and daughters of alcoholics. He attended, made friends there. As important, the father, finally confronted his own addiction. He enrolled and competed a residential alcohol program.

Jimmy is now off probation at age 16 and is again receiving A's and B's in school.

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Adolescent sons and daughters of alcohol and drug abusers make up the lion's share of all court involved youth, notwithstanding how they come to court. The inability of those agencies serving youth, including schools, doctors, social service agencies and the courts, to diagnosis the disease of alcoholism and drug addiction in the child and immediate family remains the biggest obstacle to successful intervention. In courts, judges are inadequately trained to meet the task of dealing with children from alcohol or drug impaired families. The result is irrelevant and counter-productive court action in dealing with defendants and petitioners. If judges had known anything at all about the disease of alcoholism, it would not have taken Mothers Against Drunk Driving, 25,000 highway deaths a year and federal legislation for judges to begin to deal effectively with drunk drivers. The same kind of national crusade is needed to get juvenile and adult correctional agencies to realize that there can be no effective intervention in the lives of the adolescents before them without dealing with the problems of alcohol and drug addiction. Branding kids or adults as "delinquents," "status offenders" or "criminals" does not make their alcoholism or drug addiction or that of their families go away.

Just as a doctor checks the vital signs of any new patient in an emergency ward before administering treatment, courts and social service agencies must check the adolescents' vital signs before procedding further. The first check should be a family history of alcoholism and drug addiction. Early intervention can be achieved only if the diagnoser adopts single-minded attention to the possibility of the disease of alcoholism and is not distracted by the individual's multitude of other complaints, circumstances or denials. Individuals with alcoholic parents often experience exceptionally severe symptoms before acknowledging their own abuse. Alcoholic children do not share the same symptoms as alcoholic adults.

Once diagnosed, treatment is required. Adolescents do better in treatment separated from adults. The expansion of HMO which do not pay for in-patient alcohol treatment is becoming an increasing block to treatment. While studies do not reveal that in-patient treatment is more effective than out-patient treatment in the long run, in crisis situations such as those that provoke court action it is often essential to begin the recovery process.

Treatment is made more difficult as a result of the billions of dollars invested in promoting alcohol consumption. Misleading advertising as well as ironically well-intentioned anti-drug campaigns on television are a block to treatment. Sports heros and the like extolling alcohol encourages people to drink for the wrong reasons without warning them that for some any drinking is a slow, chaotic, and painful death for them and their families. "*Saying No to Drugs*" is well and fine as long as the message clarifies that alcohol is the most pervasive and dangerous of all drugs.

Frequently, alcoholic parents tell us in court, faced with the criminal acts of their intoxicated sons and daughters, "Thank god, they aren't on drugs."

Until we increase awareness about the real drug epidemic in this country, we will all be victims of it, not the least adolescent sons and daughters of alcoholics. They will continue to crowd our court calenders and the uneducated will continue to wonder why kids do such awful things and cause their families and everyone else so much trouble.

Senator DODD. Well, you covered the waterfront there certainly. I like your description of the system being awash in alcoholism. That is as accurate and graphic as you can get.

Phil Diaz? We thank you for being here today and we are glad to receive your testimony. We will follow the same ground rules we have had for the others.

Mr. DIAZ. Thank you for inviting me, Senator Dodd. Your staff said five minutes and I am going to try to keep to that.

Senator DODD. Thanks.

Mr. DIAZ. Nobody has talked about minorities directly here, but they have every time they have talked about the juvenile justice and child welfare group home settings.

I started working with children of alcoholics in 1972 in the child welfare system for 7 years, working with kids on the lower East Side, in the South Bronx, and then in 1979 we opened up the Center for Children of Alcoholics, the first freestanding center called Project Rainbow, which had a Hispanic component.

At that time, Migs Woodside was pioneering her effort and I think today there are a lot of people in the room that Migs used to visit, she had a little car and she would drive out to the South Bronx, to Manhattan, and around the State where we were, and gather the data for the Califano report. We have come a long way, and I think that ought to be recognized today. We have come a long way from 1980, when almost nobody was was working with COA's and nobody knew about the issue and nobody cared.

I congratulate you and Senator Thurmond for being here and holding these hearings. It is a long way for us who have been out in the woods alone working with COAs, knowing how incredibly difficult it is to grow up in an alcoholic home. But for minority kids, it is a lot more difficult. You know, when we talk about children of alcoholics, and when we talk about some of these settings for COAs we are talking about middle class settings, we are not talking about poor kids, we are not talking about black kids, we are not talking about Hispanic kids, and we are certainly not talking about Native American kids. Nobody here has alluded to Native American children.

I just came back from the first ACOA training for the Seattle Indian health board, a training of Native American people to go back to reservations, to work with children of alcoholics. I was in a group where everybody was crying, every adult there. No one knew somebody who was not the child of an alcoholic in their tribe, not one person was not the child of an alcoholic in their tribe. So it is a major issue for Native Americans.

For Hispanic COA's, we found out a very interesting thing. I gave you a copy of a book that was written by one of our staff, Ron Fiqueroa, for Hispanic COA's. The first thing we found was there was nothing available culturally appropriate for Hispanic kids and certainly nothing in Spanish and English, and the reason we needed to write those things bilingually was so the parents understood what we were talking about with the kids.

What we found is that children of acculturation have the same problems as the children of alcoholics, that is, they are ashamed of their parents, they are ambivalent about being with their parents. They end up in a parenting role and that has not been discussed a lot today, but I can tell you stories of 6-year-old kids who come home to single-parent families, the mother is drunk on the floor, and the kid comes and covers her and waits for her to wake up, and he does not know if she is dead or alive, because when you try to move a drunk they feel dead.

And those kinds of situations is what we are really talking about here, kids who end up parenting their parent at a very young age and parenting the rest of the family, the parental child, and it happens a lot. In homes where there is poverty, it happens without support systems, there are no uncles and aunts coming around to take care of the situation.

For the children of alcoholics who are minority children, the justice system and the child welfare system are the treatment systems. I want to restate that, for the children of alcoholics who are minorities, the juvenile justice system and the child welfare system are the treatment system.

The children of alcoholics that I worked with on the Lower East Side and the South Bronx were sent to residential child care because of problems their parents had, and they were punished for those problems when they were put in those residential settings. No one identified that they were children of alcoholics. No one told them what was going on, and unfortunately, in child welfare systems no one sent the parents to AA. Nobody sent the parents to Al-Anon. Everybody waited for a drunk that came in that could not walk, because if you start identifying people who are in early stages of alcoholism, you might have to identify your own staff members.

There is tremendous denial in the health care and social service system to identify alcoholism, so there is also a tremendous block to identify children of alcoholics. When I was in the child welfare system, nearly none of those parents were being referred to AA and Al-Anon.

Also, for minority children another thing that we found is that more parents recovered in the church system than they did in the service mental health social system, that AA and Al-Anon, while a very positive and powerful tool for recovery for most people, are not the way most people recovered who were Hispanic. They got care and recovered in the church, and I am sure if Senator Thurmond were here he would be able to substantiate that down South, in the Bible Belt, when those revivals take place, a lot of people get better and they stop drinking.

So we need to recognize that indigenous helping systems are very important and not to be ignored when we are talking about children of alcoholics.

We need to talk about the issue of parenting as well. Studies have shown that drinking itself and the cessation of drinking itself does not necessarily make the family better. In fact, in some cases it is worse, because when the parent was drinking the child had a fantasy of what getting better was going to be about. When the parent stopped drinking, they did not know how to parent, they themselves were adult children of alcoholics—and I am not going to discuss adult children, you have people coming here to do that.

They do not know how the parent, they grew up in a world of dysfunctional behavior and they continued it. And if we are really going to try to help children of alcoholics, we have to do more than just help parents not drink and treat children in groups, we have to teach parents parenting skills, as Rosemary was saying, otherwise we do not break those generations of alcoholic parenting.

Finally, no one has talked much about the children of the heroin addicts, the methadone maintained babies. Well, one of our growth statistics today is AIDS among the infants, and we need to be real clear that this is not just a psychological problem. Children are dying who are children of alcoholics. They die from child abuse every day, they die from AIDS every day, they die from AIDS because they are born that way or there is incest in the family. No one has talked here today of the high rate of incest in the family. When the child gets AIDS, somebody has raped that child or the child has been born to a mother who had AIDS. There are only a couple of ways you are going to get AIDS.

I spoke to Lorraine Hale this morning at Hale House to tell her we were down here, and I told her that I wanted to be able to say that Hale House was beginning to work with children of AIDS and I wanted to make sure that was going to take place.

Lorraine said seven children have died in the past six months at Hale House from AIDS. It is important that we look at that issue. It is not just a minority issue, but we need to create programs that are culturally sensitive for minorities when we look at this issue. We need to be able to do things bilingually.

At the same time, we need to be aware when it is not a minority or cross cultural issue, and I am going to end with an incident in a group that happened to be when I was dealing with a bunch of adolescents. Two-thirds of our kids were always 12 and under, but we had an adolescent component.

I was in a group and there were about eight kids, some white, some black, some Hispanic, it was a cross-cultural group. We also ran mono-cultural groups for kids who were not culturated. This was a cross-cultural group. One of the white kids came in and said, "I hate that Nigger my mother goes out with." I looked at the black kids and I thought we were going to have a fight on our hands, and I also thought maybe it was time for me to do some education about racism.

In particular, my wife is a black American and I thought, you know, I really should do this, but I did not because my gut feeling was some other issue. Then some kid said, "Well, I hate the Spic my mother goes out with." I had a very different reaction to that, Senator. I felt immediately that I was going to take this kid and educate him about cultural sensitivity.

I am here to tell you that the issues for the work are very important, too, in dealing with minority kids. The kid said, "I hate that Spic my mother goes out with. All she does is drink and go out with him. All she does is drink and go out with him."

I got very nervous because they had said Spic and Nigger in a group where we had black kids and Hispanic kids, but I did not say anything about racism because I felt in my gut that it was not about racism, it was not about culture this time. And this big white kid looked at me in the face and said—he used to carry a knife in his boot and every time he got nervous in the group he would pull out the knife and clean his nails to let me know he was nervous. [Laughter.]

Those of you who work with adolescents know what I am talking about. He wore spikes on his wrist. And he said to me, "She's supposed to love me. They're supposed to love us." And he looked me straight in the eye and, you know, those of us who work with adolescents know what that moment is about, it is about "make me feel better, you got me in here to talk about my pain, now I am feeling it and you had better make me feel better."

He said, "She's supposed to love me, and all she does is drink and go out with him," and that is really what we are here about. The kid did not feel loved. He could not understand why his mother would give her attention elsewhere, and I still kept my mouth shut because I did not know what to do and I was always taught not to say anything if you could not say something constructive.

A little Puerto Rican girl in the group said, "I'm a Spic and I love you," and that group started crying and they each held each other and I said, "You know, your parents are empty wells right now. Love is present in your parents but unavailable to you right now, but you can get it from each other."

Unless children of alcoholics learn to get it from each other, they will go on marrying alcoholics. You asked that question before. It is because children of alcoholics are addicted to empty wells. They are addicted to not getting their needs met. They find people not to get their needs met. They find jobs where they cannot get their needs met, in order to continue that, because they have never experienced what it felt like.

And I said to the kids, this is what it is all about, this is what it feels like to get support, this is what it feels like to get love, this is what it feels like to be seen and heard.

So, Senator, you started something really important today and I hope it continues. I hope you understand, though, how much difficulty—and I know you do—we have convincing people out there that these services are needed for kids and, as Rosemary said, it is allowing people to run those groups, to allow kids to feel valued that we are talking about.

Thank you, Senator.

[Applause.]

[Information supplied for the record follows:]

ReadersExchange

Children of Alcoholics in the Juvenile Justice System

Patricia O'Gorman, Ph.D.
Robert A. Ross

A significant proportion of youngsters in the juvenile justice system are children of alcoholics. Although no national statistics have been compiled, a local survey conducted by the authors indicates a potentially high correlation between juvenile justice system involvement and alcoholism in the families of those involved in that system.

A review of intake material at Berkshire Farm and Center for Youth in Canaan, New York, a 232-bed nonsecure residential treatment facility for adjudicated male minors, indicated that alcoholism was by far the most frequently reported problem affecting the families of these boys—more than 55 percent of those in placement came from homes where there was an alcoholic parent or other adult. The data also showed that 18 percent of families had been investigated by Protective Services for child abuse or neglect.

Further, 60 percent of the incarcerated youngsters whose records were reviewed indicated alcohol and drug usage problems of their own. Thirty-seven percent of these came from homes where alcoholism in a family member was indicated. Since this survey relied only on intake material, these estimates must be considered conservative. The authors believe that a complete assessment would reveal an even higher incidence of family and personal alcohol problems among juvenile offenders.

The phenomenon of the alcoholic family producing children who frequently commit crimes was chronicled long ago in such works as *Ten Nights in a Bar-Room* (published in 1899). However, no serious attention has been paid to the connection between parental alcoholism and juvenile justice problems until recently. The intent of this article is to bring attention to the fact that alcoholism may be present in the homes of a significant number of those served by the juvenile justice system, and that a response to the family member's alcoholism problem may be essential to successfully addressing the problems of these youth. More widespread understanding of and commitment to this issue is also a prerequisite to developing the research and prevention efforts needed to establish meaningful intervention efforts for those children of alcoholics currently receiving juvenile justice services.

Interventions for the Family in Trouble

Often what is found when a parent or someone in the community lodges a complaint against a child, bringing him or her into the juvenile justice system, is that not only is the child before the judge in crisis, but also the whole family is troubled. The child's crisis—usually acting-out behavior—is frequently only one visible manifestation of the family's problems.

States and counties differ in the degree of assessment done on the family and child. Alcoholism, however, is usually identified only if an enlightened probation officer or social worker knows the right questions to ask. Such questions are not a part of the routine information gathered.

After some assessment, the child is brought into family or juvenile court to appear before a judge. The court can make a number of dispositions concerning the child, but it is important to note that the court does not mandate any intervention or treatment for the parents since they have not been brought before the court. The only exception to this (at least in New York State) is if Child Protective Services investigates a family and mandates treatment because child abuse or neglect is occurring. Through adjudication, the child can be placed in a detention center, in foster care, or in a group home, usually consisting of 6 to 12 youngsters who reside in a community home with staff. If a child is in need of greater structure, the child can be placed in a residential treatment facility.

Treatment Programs

Often when a youngster comes into treatment a fuller picture of the family is gathered. If a family member's alcoholism is identified as a contributor to the child's problems, a range of interventions is available to the child and the family, depending on the placement setting's resources. For example, if the child is placed away from the home, the child's return to the home can be made conditional on the parents' acceptance of help for the alcoholism problem. The threat of having the child placed away from the home or not being returned permanently to the home may be a strong motivation for a parent to initially address his or her alcoholism.

In other cases, residential treatment facilities may bring family members in for regular contact with the adolescent during placement. Through this method, all members of the family can receive counseling, following the standard intervention models.

While it is highly desirable to involve the family, in cases where families are either not available or are resistant to any involvement, quite a bit of work can still be done with the youngsters. As our intake survey indicated, many children of alcoholics who enter a juvenile facility have their own alcohol or drug abuse problems. In these cases, our experience has been that it is most effective to have the adolescent address parental alcohol abuse *first* as a way of "de-dramatizing" their own usage. Adolescents at a juvenile facility frequently exhibit much bravado concerning their own alcohol and drug abuse. Focusing on the parental drinking problems allows the youngster to admit that alcohol abuse does cause people serious problems without directly admitting their own loss of control, at least initially. Children of alcoholics are best seen as part of Alateen and in short term groups that focus initially on parental drinking and secondarily on their own alcohol and drug abuse.

Self-Identification and Motivation

Sometimes, youngsters not identified during intake as coming from an alcoholic home later identify this as a problem. Especially if a climate of acceptance has been established by counselors, this is likely to take place. At Berkshire Farm Center, one short-term group was established for boys identified as children of alcoholics at intake. Boys being seen then began to identify peers as in need of this service. Staff members began to ask more questions about alcohol problems among the boys and their families, and began to find that—when asked—many more youths identified such problems.

Information about alcoholism and children of alcoholics was provided in staff training sessions, and a traditional alcohol awareness week was held at the facility. The boys also received information on alcohol via affective education techniques in the classroom, as well as in individual and group counseling sessions.

The response was significant. What motivated these boys to seek out help with their own and family alcohol problems? Children in the juvenile justice system have been identified as being "the problem" in their families. On some level, most are aware that all is not their fault. No matter how "hardened" they may appear, they all are concerned about family members and trying to help their families.

Sensitizing the Juvenile Justice System

The experience at Berkshire Farm and Center for Youth is rare. More juvenile justice facilities need to become aware of the familial alcoholism crises experienced by the youth in their charge. However, if we are to freely address this problem, we must not only train staff at juvenile facilities, but also train family court judges, probation officers, community mental health personnel, and school personnel—all of whom are involved with problem youngsters prior to their admission to the juvenile justice system.

If family and personal alcohol problems are addressed early, will this prevent the type of deterioration of the family and the child that results in juvenile offenses? On the basis of our experience, we would say yes, but this needs to be documented through research, as do a number of other issues. What interventions work best with whom? What sequence of interventions portends the best results? The investigation of such questions raise additional concerns. For example, should alcoholism treatment be mandated when child abuse is occurring as well? This may involve alcohol training for child protective workers, as well as a change in the confidentiality regulations covering alcoholism treatment.

Preventing involvement with the juvenile justice system and facilitating intervention with troubled families are important objectives for the juvenile justice system. There is great potential for success, but only if this area receives attention from researchers, treatment professionals, juvenile justice workers, and policymakers. □

Patricia O'Gorman, Ph.D., is the chief psychologist at Berkshire Farm and Center for Youth in Canaan, New York. She is also former director of the Division of Prevention for the National Institute on Alcohol Abuse and Alcoholism (NIAAA). Robert A. Ross is the executive deputy director of the New York State Division of Alcoholism and Alcohol Abuse. The authors may be contacted at Box 300, East Chatham, NY 12060.

Hispanic Alcoholics' Children Need Extra Help

RONALDO L. FIGUEROA, M.A., C.A.C.
PHILIP OLIVER-DIAZ, M.S.W.

Children from families that are not assimilated into the mainstream of American society are often ambivalent about their parents. They love their parents but are embarrassed by their language, dress, and lifestyles. Children of acculturation grow up in a world of mixed messages, feeling guilty about their attitude toward their families and isolated from their peers.

Young children of alcoholic families often develop similar feelings of ambivalence toward their parents. Many of them must learn special skills needed to survive the chaos, neglect, violence, and mixed messages they receive from both family and society. Children of alcoholic families that are not assimilated into mainstream American culture, therefore, carry a double burden. Issues of language, housing, employment, education, immigration status, and discrimination may compound the stresses created by alcohol abuse within the family. The axiom of "deal with the drinking and things will work out" does not fit with most acculturating families in need of alcohol-related counseling.

In terms of absolute numbers, the problem of the double burden for children coping simultaneously with acculturation and alcoholism is perhaps most prevalent among Hispanic-Americans. Every year, nearly 200,000 documented Hispanic immigrants arrive in the United States; with this large a population, even a tiny percentage of families encountering problems with alcohol would result in a significant number of children affected by alcohol-related stress. Therapists need to understand that when treating Hispanic children of alcoholics, it is not enough to deal exclusively with the alcoholism in the family, for this does not necessarily eliminate the stresses on the children. The therapist must also address the stress caused by the problem of acculturation.

CULTURAL BARRIERS TO THE SELF-HELP GROUP APPROACH

The major resources that the alcoholism treatment community has referred to for continuing help for children of alcoholics and their families have been Alcoholics Anonymous, Al-Anon, and Alateen. Although there are ongoing attempts to establish culturally specific self-help groups that offer meetings in Spanish, such groups do not yet exist in sufficient number to respond to the needs of many Hispanic families. In addition, some aspects of the self-help approach may encounter barriers imposed by the value system of many Hispanics. The idea of disclosing family matters in a public forum of any kind is unacceptable in some Latin American cultures. Detachment and confrontive behavior, which have proved useful in some self-help treatment programs, pose a problem for many Hispanic-American women and children. For the Hispanic man, the sharing of personal problems in front of other men often causes a feeling of powerlessness. These factors can impede the successful adaptation of treatment and recovery techniques from mainstream programs to programs targeted at the Hispanic population.

INDIGENOUS RECOVERY SYSTEMS

The traditional Hispanic family is a large, independent, closely knit unit, commonly extending beyond the nuclear family. For many Hispanic-Americans deprived of this support group, the role of the extended family may be transferred in part to fundamentalist religious groups, such as the Pentacostal and Charismatic sects. In such cases, the church may become the primary system of recovery for families experiencing alcohol-related stress.

Among Hispanic fundamentalist churches that have developed alcohol recovery programs, the pastor of the church often plays a key role. He or she interprets what is secular and what is spiritual, and therefore lends legitimacy to the counseling process. When the pastor and designated *obreros*—church members engaged in frontline counseling—treat alcoholics and counsel family members, client participation and cooperation appear to be relatively high. This arrangement acknowledges the need to address the spiritual aspects of the addiction in a culturally relevant manner. It also tends to reinforce mutual respect for all persons involved in aiding the recovery process.

Other indigenous Hispanic recovery models are based on spiritual systems that date back to the Native American and African roots of many of the Latin American subcultures. These traditions incorporate a long cultural history of attempting to help alcoholics through a combination of herbal medicine, enlisting the aid of spirits, and faith healing. In some parts of the United States, the practitioners of these traditions hold positions of respect among members of the Hispanic community; an understanding of their approach to treatment is necessary for counselors who are trying to help the children of parents who have sought assistance from such traditional sources of help.

Accurate estimates of the number of alcoholic families within the Hispanic community who seek recovery from fundamentalist churches or traditional syncretic religions are not available. However, it is reasonable

National Council of La Raza

The therapist treating Hispanic children of alcoholics must be prepared to address the additional stress imposed by the problem of acculturation.

to believe that a large number of Hispanics who are less assimilated to mainstream American culture seek help through this kind of intervention. When working in a Hispanic community with the children of alcoholics, it is, therefore, important to be knowledgeable of the techniques of the indigenous practitioners and to be prepared to elicit their cooperation in order to provide effective counseling for Hispanic alcoholic families.

In addition, help for Hispanic children from alcoholic families will require major initiatives in social service and juvenile justice systems. Many children in foster care are children of alcoholics. Although systematic studies have yet to be done, the literature on Hispanic children of alcoholics suggests that most COAs end up in the juvenile justice and social service systems, not in the alcohol treatment system. This is also true of the foster care system, where children of alcoholics are often punished for their parents' dysfunctional behavior. Help for Hispanic children from alcoholic families will require major initiatives in these systems. They need efficient and relevant help, through skillful counseling and suitable programs. Until such efforts meet with success, the Hispanic offspring of alcoholics will continue to be children adrift. ■

RONALDO L. FIGUEROA, M.A., C.A.C., is executive director of the Rockland Council on Alcoholism, Inc. PHILIP OLIVER-DIAZ, M.S.W., is director of the Division of Alcohol and Substance Abuse Programs, Rockland County Medical Health Center. Mr. Figueroa can be contacted at the Rockland Council on Alcoholism, 1 South Broadway, Nyack, NY 10960. Telephone: (914) 358-4357.

BOOKS for Young Children of Alcoholics and Other Children of Trauma

Edited by
Patricia O'Gorman and
Philip Oliver-Diaz

Books on Alcoholism and Reaching Out

Brooks, Cathleen. **The Secret Everyone Knows.** The Kroc Foundation, San Diego, California, 1981.

Black, Claudia. **My Dad Loves Me, My Dad Has A Disease.** Medical Administration Company, Denver, Colorado, 1982.

Culin, Charlotte. **Cages of Glass, Flowers of Time.** Scarsdale, NY: Bradbury, 1979. Ages 12-16

Figueroa, Ronaldo. **El Secreto de Pablito.** Pompano Beach, Florida: Health Communications, 1984. Ages 7-12.

Hammond, Mary and Chesnut, Lynnann. **My Mom Doesn't Look Like an Alcoholic.** Health Communications, 1986. Ages 7-12.

Hornick, Edith. **You and Your Alcoholic Parent.** New York, Association Press, 1974. Ages 11-16

Mazer, Harry. **The War On Villa Street.** Dell, 1978. Ages 12-14

Norris, Gunilla. **Take My Walking Slow.** Atheneum, 1970. Ages 5-8

Seixas, Judith S., **Alcohol — What It Is, What It Does.** Greenwillow Books, 1974

Seixas, Judith S., **Living With A Parent Who Drinks Too Much.** Greenwillow Books, 1979.

Stanek, Muriel. **Don't Hurt Me Mama,** Albert Whitman, 1983. Ages 5-8.

Books on Child Abuse and Children Rights

Anderson, Mary. **Step On A Crack.** Atheneum, 1978. Ages 13-16.

Bradbury, Blanca. **Those Traver Kids.** Houghton Mifflin, 1972. Ages 13-15.

Byars, Betsy. **Cracker Jackson.** Viking/Kestrel, 1984. Ages 11-14.

Byars, Betsy. **The Pinballs.** Harper Row, 1977. Ages 1-13.

Cunningham, Julia. **Come To The Edge.** Avon, 1978. 11-13.

Edward F. **Child Abuse.** Watts, 1980. Ages 13-16.

Hamilton, Virginia. **Sweet Whispers, Brother Rush.** Philomel, 1982. Ages 13-15

Haskins, James. **The Child Abuse Help Book.** Albert Whitman, 1981. Ages 11-14.

Moeri, Louise. **The Girl Who Lived On The Ferris Wheel.** Dutton, 1979. Ages 11-14

Roberts, Willo Davis. **Don't Hurt Laurie!** Atheneum, 1977. Ages 11-13.

Weik, Mary. **The Jazz Man.** Aladdin, 1977. Ages 8-12.

Books on Child Sexual Abuse and How to Protect Oneself

Bauer, Marion Dane. **Foster Child.** Clarion, 1976. Ages 11-14.

Borech, Michael. **A Different Kind Of Love.** Holt, 1985. Ages 14-16.

Girard, Linda W. **My Body Is Private.** Albert Whitman, 1984. Ages 4-8.

Hall, Lynn. **The Boy In The Off-White Hat.** Scribner, 1984. Ages 12-14.

Irwin, Hadley. **Abby, My Love.** Antheneum, 1985. Ages 13-18.

Terkel, Susan N. and Rench, Janice E. **Feeling Safe, Feeling Strong: How To Avoid Sexual Abuse and What To Do If It Happens To You.** Lerner, 1984. Ages 10-12.

Wachter, Oralee. **No More Secrets For Me.** Little Brown, 1983. Ages 7-9.

Books on Anorexia Nervosa and Getting Help

Hautzig, Deborah. **Second Star To The Right.** Greenwillow Books, 1981. Ages 12-16

Ruckman, Ivy. **The Hunger Scream.** Walker, 1983. Ages 12-15

Books on Dealing With A Parent in Prison

Alcock, Gudrun. **Turn The Next Corner.** New York: Lothrop, Lee & Shepard, 1969.

Burch, Robert. **Queenie Peavy.** Illus. by Jerry Lazare. New York: Viking Press, 1966.

Madison, Winifred. **Marinka, Katinka, and Me (Susie).** Illus. by Miller Pope. Scardale, N.Y.: Bradbury Press, 1975.

Zindel, Paul. **I Love My Mother.** Illus. by John Melo. New York: Harper & Row, 1975.

Books On Divorce And How Kids Deal With It

Blume, Judy. **It's Not the End Of The World.** N.Y. Bradbury Press, 1972.

Cain, Barbara, and Benedek, Elissa. **What Would You Do? A Child's Book About Divorce.** Illus. by James Cummins. Ind.: The Saturday Evening Post Company, 1976.

Gardner, Richard A. **The Boys And Girls Book About Divorce.** Illus. by Alfred Lowenheim. New York: Science House, 1970. Ages 10-18.

Goff, Beth. **Where Is Daddy? The Story Of A Divorce.** Illus. by Susan Perl. Boston: Beacon Press, 1969.

Mann, Peggy. **My Dad Lives In A Downtown Hotel.** Illus. by Richard Cuffari. Garden City, N.Y.: Doubleday, 1973.

Books on Kids and Single Parenting as a Positive Experience

Eichler, Margrit. **Martin's Father.** Illus. by Bev Magennis. Chapel Hill, N.C.: Lollipop Power, 1971.

Gilbert, Sara. **How To Live With A Single Parent.** Lothrop, Lee & Shepard Books, 1982. Ages 10-17.

Stanek, Muriel. **I Won't Go Without A Father.** Illus. by Eleanor Mill. Chicago: Albert Whitman, 1972.

Surowiecki, Sandra. **Joshua's Day.** Illus. by Partricia Riley Lenthall. Chapel Hill, N.C.: Lollipop Power, 1972.

Zolotow, Charlotte. **A Father Like That.** Illus. by Ben Shecter. New York: Harper & Row, 1971.

Books on Mental Illness in Kids and Their Parents

Piowaty, Kim Kennely. **Don't Look Into Her Eyes.** Atheneum, 1983. Ages 11-13.

Platt, Kin. **The Boy Who Could Make Himself Disappear.** New York: Walker, 1983. Ages 11-16.

Books To Help Counteract Fears of Abandonment

Brown, Margaret W. **The Runaway Bunny.** Illus. by Clement Hurd. New York: Harper & Row, 1942.

Krauss, Ruth. **The Bundle Book.** Illus. by Helen Stone. New York: Harper & Row, 1951.

Schlein, Miriam. **The Way Mothers Are.** Illus. by Joe Lasker. Chicago: Albert Whitman, 1963.

Books To Encourage Open Expression of Feelings

Berger, Terry. **I Have Feelings.** Human Service Press, 1971.

Blaine, Marge. **The Terrible Thing That Happened At Our House.** Illus. by John C. Wallner. New York: Parents' Magazine Press. 1975.

Fassler, Joan. **The Boy With A Problem.** Illus. by Stuart Kranz. New York: Behavioral Publications, 1971.

Krasilovsky, Phyllis. **Scaredy Cat.** Illus. by Ninon. New York: Macmillan, 1959.

Marks, Jane. **Help! My Parents Are Driving Me Crazy.** New York: Ace Books, 1982.

Palmer, Pat. **Liking Myself.** Calif.: Impact Publishers, 1977.

Paulus, Trina. **Hope For The Flowers.** New York: Paulist Press, 1977.

Preston, Edna Mitchell. **The Temper Tantrum Book.** Illus. by Rainey Bennett. New York: Viking Press, 1969.

Viorst, Judith. **Alexander And The Terrible, Horrible, No Good, Very Bad Day.** Illus. by Ray Cruz. New York: Atheneum, 1975.

Vogel, Ilse-Margret. **The Don't Be Scared Book.** Atheneum, 1964.

Williams, Margery. **Velveteen Rabbit.** Hearst, 1975.

Wright, Dare. **The Lonely Doll.** Garden City, New York: Doubleday, 1957.

Zolotow, C. **The Hating Book.** Harper & Row, 1963.

Zolotow, C. **The Quarreling Book.** Harper & Row, 1963.

Self-Help Resources

Al-Anon, Al-Anon Adult Children of Alcoholics and Alateen Family Groups
POB 862 Midtown Station
New York, N.Y. 10018-086

Alcoholics Anonymous
Box 459
Grand Central Station
New York, N.Y. 10163

Adult Children of Alcoholics
POB 35623
Los Angeles, Calif. 90035

Batterers Anonymous
POB 29
Redlands, Calif. 92373

Debtors Anonymous
POB 20322
New York, N.Y. 10025-9992

Divorce Anonymous
POB 5313
Chicago, IL 60680

Emotions Anonymous
POB 4245
St. Paul, MN. 55104

Families Anonymous
POB 344
Torrance, Calif. 90501

Gamanon
POB 967
Radio City Station
New York, N.Y. 10019

Gamblers Anonymous
POB 17173
Los Angeles, Calif. 90017

Incest Survivors Anonymous
POB 5613
Long Beach, Calif. 90805

Nar-Anon Family Groups
350 5th St., Suite 207
San Pedro, Calif. 90731

Narcotics Anonymous
POB 9999
Van Nuys, Calif. 91409

National Single Parent Coalition
10 W. 23 St.
New York, N.Y. 10010

O-Anon
POB 4305
San Pedro, Calif. 90731

Overeaters Anonymous
4025 Spenser St., Suite 203
Torrance, Calif. 90503

Parents Anonymous
22330 Hawthorne Blvd.
Torrance, Calif. 90505

Parents Without Partners
7910 Woodmont Ave.
Wash., D.C. 20014

Pill-Anon Family Programs
POB 120 Gracey Station
New York, N.Y. 10028

Pills Anonymous
POB 473
Ansonia Station
New York, N.Y. 10023

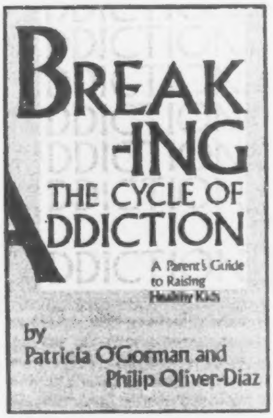
Prison Families Anonymous
134 Jackson St.
Hempstead, N.Y. 11550

Single Dad's Hotline
POB 4842
Scottsdale, AZ. 85258

BREAKING THE CYCLE OF ADDICTION

A Parent's Guide to Raising Healthy Kids

by
Patricia O'Gorman
Philip Oliver-Diaz



Breaking the Cycle of Addiction is for parents and parents-to-be who were raised in addicted or dysfunctional families. By specifically addressing the issues of adults who have been affected by an alcoholic or an addicted parent, this guide teaches parents about *Breaking the Cycle of Addiction* from their generation to their children's. *Breaking the Cycle* speaks to parents struggling with their own or a spouse's addiction, including gambling, drugs, compulsive spending, overeating and workaholism, by defining what is normal and how to get there. This well organized guide not only teaches parents how to raise their kids to be healthy and normal but also how to parent the child within themself.

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Florida residents add 5% sales tax.

Senator DODD. That is good. I do not know if Jim Neal, a southerner, could follow that speed of a New York accent there.

Mr. NEAL. I felt it, Senator.

Senator DODD. An excellent job. I just sensed about 10 years of frustration out here. I regret we do not have more people paying attention, but it is a beginning and we will not let it end here.

Lastly, Ellen, I appreciate your patience in waiting and we will be glad to receive your testimony. It is a tough act to follow.

Ms. MOREHOUSE. A very tough act to follow.

Thank you for having me here today. As you said, I am the Director of the Student Assistance Program. Last year, we saw approximately 1,200 adolescent children of alcoholics. I am speaking specifically today about children of alcoholics in grades 9 through 12, in other words, mid- to late-adolescent stage.

I would like to describe for you some of the issues and concerns that they have. A lot of people today have talked about alcoholism and drug use. That is only one problem of adolescent children of alcoholics. Some of the other problems they have are as follows:

The first area where they have problems is in the whole area of separation. Adolescence, as you probably know, is a transition stage where kids need to get ready to leave home. For many of these kids, they go through an incredible struggle, especially at this time of year—if I join the Marines or the Army, who is going to help pay the rent, who is going to make sure that dad does not beat up on mom; if I decide to go away to college, who is going to love me, who is going to make sure that I have a birthday, no one did at home, my aunt remembered, but away at college my aunt will not even be there.

There is an expression, and you may be familiar with it, it is hard to leave the table when you have not had enough to eat. For many children of alcoholics, it is hard to leave their homes when they have had empty wells, where they have not had the nurturing that they needed as children. Because of this, many look to peers to provide the nurturing they need, as Phil just referred to. They try to find a boyfriend or girlfriend to remember their birthday, who is going to provide all the love and care that they did not get from their parents.

No adolescent can possibly parent another adolescent, since starting in early adolescence these kids learn that they are never going to get their needs met, that no one will ever love them enough, care for them enough, and they constantly get frustrated and begin to build walls and begin to retreat into their interpersonal relationships.

The third area where these children have problems is in the whole area of depression and guilt. Around the age of mid-adolescence, these children begin to realize that it is too late to have the kind of Christmas they always wanted, with presents under the tree, it is too late to have the kind of Thanksgiving that kids are supposed to have, and at 14, 15, or 16, if I want these things, the only person who will be able to provide it is me, as an adult. This is not supposed to happen to adolescent aged kids. It is supposed to happen when you are 25, 30 or 40, when you begin to realize that your parents are people and that you depend on yourself to meet your needs.

The next area where these children have problems is in the whole area of guilt. Many of these children really believe that they are more valuable to the opposite sex parent than their same sex parent is. Let me explain what I mean by that, and I will give you two instances.

Father and son are watching television. The father is the alcoholic. The mother comes into the living room and says, "Honey, I forgot to get milk and eggs at the store. Can you give me a few dollars?" Father starts to fumble through his pockets and mom goes, "Not, you, I'm going to ask the real man in this family," and looks at her 14-year-old son. Imagine what it is like to be that 14-year-old son.

Or let us move the income level up a little bit. Dad is on a board and he has a board meeting at night. Mother and daughter are washing dishes in the kitchen. Father comes in and he is wearing his sports jacket and he says, "Honey, what tie looks better with this sports jacket?" And the mother starts to talk—and mom is a Valium abuser—and father says to mom, "You are so out of it, you wouldn't know if this tie had polka dots or stripes," and then asks his 14-year-old "real woman" what she thinks.

These kids are constantly living with an incredible sense of guilt, the guilt that comes from knowing that you are more valuable to your opposite sex parent and hearing it confirmed with statements such as "I don't know what I would do if you ever left, I don't know how I could make it without you." The case that Mr. Klein gave you is a perfect example, the mother who says to her alcoholic child, "Please come home and take care of me."

Another problem these kids have is incredible embarrassment and stigma. As they move to adolescence, they have a much better sense of what an adult is supposed to be like and they become more acutely aware that that is not their parent. Whether your father gets drunk and passes out at a ghetto bar or at a country club dance, the embarrassment is incredible. These kids start to go through extraordinary lengths to protect the family secret. They start to avoid the junior or senior prom to make sure that the boy they have been dating does not see what kind of house they live in, they start to avoid graduation and trying out for the senior play because they do not want parents to show up drunk and have the school find out what they are like.

Another problem that these children have are problems of identification. In adolescence, that is the time when identity is solidified. For many of these kids, they feel that listening to their parents and getting a sense of how their parents feel about them is like looking in a mirror and getting a different reflection.

I would like to just give you the quick example of Karen. Karen was a bright 16-year-old, very attractive, real class leader, really involved adolescent. When her dad was sober, he would tell her how much he loved her, how proud he was of her, but when he was drunk he would call her a no-good tramp, say that she did not work hard enough, and that he was really ashamed of her.

Karen's identity was as a no-good girl. She really felt that alcohol acted as a truth serum and what her dad said to her when he was drunk was how he really felt, alcohol just gave him the courage to say it. So here was someone who was really doing very well, who had the self-esteem, someone who should not have been doing very well.

These are just some of the problems of adolescence. I think it is important to realize that there is a tremendous shortage of services for these kids. I advocate placing services in schools. You alluded to the fact that schools are being overloaded right now, they are being asked to provide education on all kinds of issues.

Children of alcoholics need more than education. They need someone who they can talk to, who can help them understand how their parents' drinking and drug use has affected them, and, most importantly, that they can do about it. That will not come just from the curriculum. It will not come just from something like Dial 911 if your parents pass out.

Helping someone understand what to do with the guilt, how to deal with the embarrassment, how to deal with issues around leaving home are certainly more than a 30-second public service announcement.

Thank you for the opportunity to speak today.

Senator DODD. Thank you very, very much for your testimony. Like the previous panel, you have already covered an awful lot of turf. I am glad you were here to listen to the other questions that were raised and to comment on them, because it helps tremendously. It helps me, at any rate. I regret that we do not have more members of the Committee here. It is not their fault. Unfortunately, there are so many things going on simultaneously in this place, but I promise that they will get at least a synopsis of what you said.

I was going to ask you about the Just Say No campaign. You brought that up, Mr. Klein, and Mr. Neil I think alluded to it as well, the effectiveness of those programs.

How about teachers? I understand that the education and treatment components are essential, but the point that I raised with Joe Califano this morning is not an insignificant one. There are countless areas that we are asking our school systems to address. We also know that the system is struggling with teaching children basic skills. How much can you expect an educational system to meet the need for education on alcohol abuse. I have my doubts it can be done.

We will begin with you, Ellen.

Ms. MOREHOUSE. I would like to respond. Educational systems right now are responding to the problems of truancy, they are responding to the problems of students who are not doing more at school, they are responding to vandalism, and they respond by providing counselling to the guidance department or testing through the school psychologists, or home visits through the school social worker, or disciplinary actions through the assistant principal or dean.

If we could force graduate schools in education and social work psychology to have some course work about the special issues of children of alcoholics, that an assistant principal may learn that the tough 18-year-old is always getting into fights because someone is talking about his mother and he is not going to let anyone talk about his mother that way, instead of just suspending him and providing home tutoring and doing all the things that schools do, they could deal with the central issue which is how to deal with the shame and embarrassment of being a child of an alcoholic. We need to train school personnel that being the child of an alcoholic is the central issue, it is not Just a symptom, and that so many of the problems they spend time and money dealing with will go away if you work with that central issue.

Senator DODD. Does anyone else have any comments? Does anyone else have anything to add?

Mr. DIAZ. Just again dealing with minority kids, the dropout rate in New York City is 50 percent before the 10 grade, so that for certain populations you have got to go beyond school based programs, you have got to be talking about community based programs and you have got to be talking about programs in closed systems, like churches, because for some folks, no matter what you say in a school system, it is secular and it is not counted unless it is done by Clergy—you have to educate the clergy. That is the other place that kids live, they live in church.

Senator DODD. Tell us about the unique problems faced by minority children, Phil. You have mentioned the bilingual programs. Is there anything else about a child coming from Hispanic culture in terms of alcoholism? Are there things that we are just not sensitive to in a society that still has its programs pretty much determined by the Anglo community? Are there differences some are hesitant to bring up because they might sound as they though they were being racist in some way? Are there any things that we ought to be more sensitive to?

Mr. DIAZ. Senator, it is really about acculturation for almost any group. I will give you one brief example. We ran a mono cultural group for children, Hispanic children who are Pentecostal, that meant they went to church every night, and we forget what we teach our kids, they believed in heaven and hell, and most of these kids were children of dead alcoholics.

Now, their major pressure was that their fathers were in hell, and in working that COA group with them to help them understand the disease caused tremendous stress for them, because they were praying for their fathers every night.

I had an Irish kid whose father was a cop. During a divorce case, the father goes to court and puts his hand on the Bible in front of the Judge and swears to tell the truth and then lies. The father is an alcoholic. The kid is a 10-year-old child of an alcoholic. It is an Irish situation. The kid came back to the group and she was terrified, not about her father's drinking but that he was going to go to hell because here was her dad, who is a cop, in front of a Judge, and she goes to Catholic school, and he is lying.

So part of what I am talking to you about is being culturally sensitive to all the cultures that the kids come from. With the Hispanics, you know, there is a real difference in view by class. The middle class is one group and I am not talking about the middle class. About substance use, you have to look at that.

I had a kid killed on her 14th birthday, shot to death, the child of an alcoholic. Her grandmother was a pusher in the South Bronx. That has to do with the economic realities as well as ethnic minorities. That kid was Puerto Rican. A middle class Puerto Rican family is not going to respond the same way.

When I went to get her two brothers for her funeral, they were downtown pimping, all children of alcoholics. Her mother was the adult child, because her grandmother was a pusher, she was the child of an alcoholic and those two kids down on 42nd Street, one was 10 and one was 11, the two boys, all children of alcoholics.

Senator DODD. Do you know of any model programs, either in the New York area or elsewhere, that seem to be good at working with minority youth and alcohol education treatment? Are there things that we ought to do? Are there particular projects that are worth looking at?

Mr. DIAZ. I think what we ought to really start doing first of all is bring these folks together. I know that ADAMHA is now OSAP, is now bringing a group together for blacks and plans a conference for bringing groups together next year. Maybe it should happen before next year for Hispanics. The same should be done for Native Americans, to see what is being out there. We piloted a model for Hispanics, but there are other models. MIBCA in Minneapolis has done stuff with blacks, but there are groups that we just do not know about. I think right now we need to have a knowledge transfer conference to see what prevention models have been piloted and what the results are for Hispanics, for Native Americans, for blacks.

Senator DODD. I mentioned earlier the Omnibus drug bill. There are provisions I put in there for at-risk youth and substance abuse prevention and treatment projects. Have any of you been contacted about what those model projects for at-risk youth ought to look like? I do not know what they ought to look like. Are they in touch with you?

Ms. NEAL. Yes.

Senator DODD. They have been?

Mr. NEAL. The deadline for proposals are this Friday, Senator.

Senator DODD. What is that?

Mr. NEAL. The deadline for proposals for those is this Friday. A lot of us are working on proposals for some of those models.

Senator DODD. Well, it might he worthwhile to get something together. I would be interested to know what you have in mind and then follow it. It is encouraging to know they have been in touch with you. It is good news that the Office of Substance Abuse Prevention is doing that.

What would you recommend, Mr. Klein, in the juvenile justice area? Obviously we need training for the professionals. What sort of training do judges get? I know they go through these week or two-week training programs on how to be a judge, even though they may have practiced for years before the courts, as attorneys. Do you find that there is any kind of sensitizing that goes on for judges about the living conditions of many of the defendants, such as alcoholic homes?

Mr. KLEIN. It is different for every State. A lot of States use the Judges College in Reno, but if you look at their curriculum you will see it is very minimal in regard to sentencing in general and specifically in regard to the problem of alcoholism. There is a lot of denial in the judicial system, like any other. Judges do not want to deal with alcoholism that is not their problem, because once they start they will have to deal with alcholism in the families. It is hard enough dealing with criminals, much less alcoholics, so there is a lot of denial in the system.

The American Bar Association has a magazine called Judges Journal and is beginning to do focus on alcoholism and Reno is beginning to open up some courses on that, because it is just such vast problem it is a little hard to ignore these days. But something that could happen is OJJDP in the juvenile justice area or the Justice Department could start focusing more attention on that and more training through NIC, et cetera, which would be very helpful and I think would be a very good beginning, because judges are sort of your de facto leaders of a disorganized criminal justice system, so that would be very helpful.

Senator DODD. I should know this but I do not. Are there jurisdictions that require minimum training in certain areas in addition to whatever other——

Mr. KLEIN. All States are different. Some States have judicial institutes and Judges have to do so much training. Generally, however, you will find that the standards and the in-service standards for hair dressing is about twenty times as high as that for being a judge in most States. And with cutbacks, California I think just stopped sending Judges out of State for training, so the training is minimal usually.

Senator DODD. What are some of the good States that you are familiar with?

Mr. KLEIN. Well, Michigan I think has a very active training program. I think the Judges College is very good. The National Council of Family Juvenile Court Judges do their own training also at the National Judges College and get involved in this. Massachusetts is very poor. I do not know about others.

Senator DODD. I would like to see what Michigan does specifically. We might get in touch with them and promote that.

Mr. KLEIN. Pennsylvania also is a very good one. They have something called a Juvenile Judges Commission and they do very excellent training, so I think Pennsylvania would be another model you ought to look at.

Senator DODD. Terrific. Again, like the last panel, I could go on a good part of the day just with this panel. As you pointed out, we have three more witnesses who will deal with adult children. We have been trying to cover early childhood, adolescence and adulthood and any one of them could have consumed a day.

This has all been obviously very compelling. I have learned a lot. It is helpful to me and we will try and move forward with some of these things. We will be in touch with you in the coming weeks and months as we try to raise the level of awareness and come up with some sound, intelligent ideas on how we can contribute to reducing this real plague that is growing all the time.

I thank all four of you for being here.

The last panel, the fourth group of witnesses, will focus on the risk faced by adults who have grown up in homes where there has been chronic alcohol and drug abuse. We have three witnesses. Cathleen Brooks, President of the National Association of Children of Alcoholics, South Laguna, California. Cathleen is also the founder and President of the Next Step Program, working with children of alcoholics.

Frank Rothgeb, Assistant Vice President for Investments, Johnston, Lemon and Company, here in Washington. He is also the President of the Washington Area Association for Children of Alcoholism and Other Addictions, a Chapter of the National Association of Children of Alcoholics. Alcohol abuse affected his own family, as I am sure we will hear. Frank is now working as a volunteer with several adolescent treatment centers.

And lastly, Beverly Jones, who is Program Manager for Child Protective Services, State of Maryland. She is a licensed certified social worker and has worked in child protective services for well over a decade. She will soon be leaving the Maryland department to work for the Child Welfare League here in Washington. We hope we will be seeing you with some frequency before this Committee.

I hope you will forgive me, all three of you. You have been extremely patient. I always imagine that I am going to be able to do all of this in a couple of hours and then obviously I get into it and it takes longer. But it is fascinating and I am learning a lot. The next time we have you before us, you will be the first panel. We will start with adults and we will work backwards. Too often things thin out when we get to the last group, but I again thank you for being here.

Cathleen, we will begin with you. I know where you are from. My former in-laws live in Carona Del Mar, California, not very far from Laguna. We welcome you. You have come a long way.

STATEMENT OF CATHLEEN BROOKS, PRESIDENT, NATIONAL ASSOCIATION FOR CHILDREN OF ALCOHOLICS, SOUTH LAGUNA, CA; FRANK ROTHGEB, ASSISTANT VICE PRESIDENT FOR INVESTMENTS, JOHNSTON, LEMON & COMPANY, WASHINGTON, DC; AND BEVERLY W. JONES, PROGRAM MANAGER FOR CHILD PROTECTIVE SERVICES, DEPARTMENT OF HUMAN RESOURCES, STATE OF MARYLAND

Ms. Brooks. Thank you.

Senator Dodd, I actually live in San Diego, where I am the founder and executive director of Next Step, a national training, education and consulting program which creates model programs for children of alcoholics in various settings.

I also serve as president of the National Association for Children of Alcoholics [NACoA] and it is NACoA's national office which is located in Sough Laguna

Senator Dodd. All right.

Ms. Brooks. So I get to travel up that beautiful piece of highway frequently.

I cannot really tell you how personally important this is to be here today. I was sitting looking over my notes and what I realized is that, I could not begin without telling you that, for a little girl who grew up in New Jersey with two alcoholic parents, the fifth generation of children of alcoholics in my family, who thought that no one would ever want to hear what had happened and who thought that the world would end if anyone ever found out. This is really a very proud moment of my life.

I am here representing the National Association for Children of Alcoholics. We are an organization of 6,000 members, many of whom have shared the experiences that you have been hearing about this morning. We are an organization that started just four years ago. We were started by about 18 of our original board members, two of whom you just had the pleasure of hearing from, Phil Diaz and Ellen Morehouse.

We came together for exactly the purpose that is now culminating in this hearing. We came together to share what we knew about children of alcoholics. We came together to join forces to speak out against the silence and the shame and the generational tragedy.

I have to be honest with you, when we came together we were not certain what kind of response we would have. Well, I think 6,000 members four years later tells you something.

There were people who came before us, Migs Woodside and the Children of Alcoholics Foundation, have been incredible in their pioneering efforts to get this issue focused on.

The National Council on Alcoholism has been at the forefront of bringing awareness about these issues to the American public.

NACOA was founded with the purpose of creating an education, information and resource organization that would be membership based. Because so many of our members, as well as our leadership are themselves adult children, we are energized by our survival and the joy of our survival. We are energized by an absolute fervor to see that what happened to so many of us will not and does not have to happen to the children who are currently growing up in alcoholic families.

There has been, as I am sure you have heard, an explosion, an absolute explosion of interest in this area. Senator Thurmond mentioned his disappointment that there was not more media attention of this hearing. I just what to tell you some of the major media where this issue has received coverage.

In the last year, we have been on the CBS Morning Program, The Donahue Show, Opra Winfrey, 57th Street, Nightline, Hour Magazine, and 60 Minutes.

Senator Dodd. You have done okay.

Ms. Brooks. That is in part a result of just the fact that this issue has been lying dormant for so very long and now in the explosive interest, people like myself and the other people who have been testifying to you today are saying we do not have to be quiet about this any more.

The interesting thing is that when you look at that one out of eight Americans are children of alcoholics statistic, I want us to think a little bit about who those one out of eight are when they become adult age.[1] Many of them become the leaders of our society. Why? Because we have been in that role since we were little children. Many of us become the people who help others and we become very good at it. We become crusaders. We become people who want to right wrongs.

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[1] Refers to earlier testimony.

In general, the adult child population that I have had the opportunity to work with, not only in an advocacy, networking and leadership basis with the national association, but in my own clinical work in San Diego, where we work with young adolescent and adult children of alcoholics in treatment as well as educational programs, in general those adult children that I work with are some of the most powerful, personally charismatic, personally giving people that I have ever met, and so what I am going to tell you about what we know about them clinically may seem confusing.

They have astonishingly low self-esteem as a rule. I want to tell you about a man who lives in San Diego, a leader in the community, who came to me for help because his marriage was falling apart. When he described himself to me, he described himself as a man who had suffered many failures in his life. This is a man whose good works I read about on a weekly basis in our local newspaper. He never, ever mentions those. When I mentioned them, he said, "Yeah, I'm really fooling people, aren't I?"

I want to tell you about a woman who came to me, a 65-year-old grandmother who came to me because she had watched the generational cycle that had begun when her father committed suicide by shotgun blast to his head in front of her when she was a child. She had watched the generational cycle continue to the point that she married an alcoholic. She had an alcoholic son and he is now abusing his young child. She came to me to say, "Cathleen, I have got to end the madness, I have got to do something." But she did *not* come saying "I deserve happiness". She did not think she did.

I think something that has been missing from our testimony to you today is stories of recovery. I am pleased to tell you that every single member of that generational cycle is now in treatment. We believe that there is a chance that the madness will be ended in that family.

What we are here to say is not only this is an enormous problem, but we have some ideas about some things that need to be done in order to end the madness.

Phil mentioned the Native American population. I have just returned from one of my visits up to the Flathead Indian Reservation in Montana, where we are working to develop a model program for children of alcoholics there.

We have a population of 5,000 Native Americans on that reservation, and not one of them that I have ever talked to does not identify themselves as the child of an alcoholic. I have gotten to the point where out of pure politeness I stopped asking people about their families, because it always brings up so much pain about the brother that was murdered, the father that died of alcoholism. It has been a people of hopelessness, but it is not any more because that community has made a commitment and the commitment is that they must begin the healing from within.

They are not just looking at their children, they are looking at the need to heal the adult children of alcoholics themselves. They are the care providers. They are people who are doing the good works. They need to heal because the syndrome that you have heard described today does not magically disappear when the child reaches adulthood. In fact, it often becomes more rigidified.

We have heard that they become alcoholics. We have heard that they marry alcoholics. I think it makes sense that they marry alcoholics. If you learn what love is in your family of origin, then you identify love in a similar fashion in adolescence and adulthood.

But what we know is that with treatment, with real resources available, intervention can occur. I want to just close with the statement of what the National Association for Children of Alcoholics has developed as their national agenda, and I would like to share it with you because I think it might give some focus for what we might be able to accomplish.

First of all, we want to see a training system developed where human service providers, including educators, physicians, health and human service workers, clergy, criminal justice, child care and social service workers, as well as alcoholism counsellors all be trained to identify these issues.

Yes, I know I have just described half the world, but what we have realized is that half the world are the people who are currently missing these kids.

I was asked by a newsman today "why have we not heard about this before?" We have not heard about it before because we are all participating in the silence, and if we are to break that we all need to work together. The next statement would be that all Federal, State and private sector alcoholic and drug programs be mandated to provide age appropriate prevention, intervention and treatment that is specifically designed for children of alcoholics and other drug abusers, regardless of whether their parent is in treatment.

The third, to establish a coalition comprised of persons from multidisciplinary fields to generate and disseminate a body of knowledge and principles to define effective standards in the area of identification, intervention and treatment for children of alcoholics and other drug abusers.

I would like to say that I believe that process has actually begun today.

Four, that early identification and intervention programs and support systems targeted at children of alcoholics and other drug abusers be implemented in every school from preschool to college levels.

Because of your commitment and because of the commitment of the people that I have had the honor to share this table with today, we are going to heal a wound that has been ignored, mistreated and misdiagnosed, a wound that just simply gets carried from generation to generation. My grandparents died of this disease. My father recovered from the disease and died of its medical complications.

I am going to be in the first generation of my family and I am working to help others be in the first generation of their family to recover not only from the disease but from the impact of the loss of childhood that you have heard described today.

Thank you.

Senator Dodd. Thank you very much, Cathleen. It is very compelling testimony.

[Information supplied for the record follows:]

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NATIONAL ASSOCIATION FOR CHILDREN OF ALCOHOLICS

"...founded on a spirit of unity, compassion and deep concern for all those affected by alcoholism."

RESOLUTION OF THE NATIONAL ASSOCIATION FOR CHILDREN OF ALCOHOLICS

WHEREAS, an estimated 28 million Americans are children of alcoholics and/or other drug abusers and, at least, 7 million are under the age of 18, and

WHEREAS, in up to 90% of child abuse cases, alcohol and/or other drugs are a significant precipitating factor, and

WHEREAS, children of alcoholics and/or other drug abusers are at highest risk for abusing alcohol and other drugs, and

WHEREAS, medical research has shown that children of alcoholics and/or other drug abusers are also at highest risk for developing stress related medical problems, alcohol/drug related birth defects and psychological and social impairment,and

WHEREAS, children of alcoholics and/or other drug abusers represent a significantly high number of those being sent to criminal and juvenile justice systems, prisons, social services, mental health facilities and school authorities,and

WHEREAS, these human services systems do not have adequate access to information and training in the areas of identification, intervention and/or referral;

THEREFORE, BE IT RESOLVED that support and funding be provided to secure the following priorities:

1. Training in the developmental and psychosocial needs of children of alcoholics and/or other drug abusers be established for educators, physicians, health and human services workers, clergy, criminal justice, child care and social service workers and alcohol counselors in the areas of identification, intervention and/or referral.

2. That all federal, state and private sector alcohol and drug programs be mandated to provide age appropriate prevention, intervention and treatment that is specifically designed for children of alcoholics and/or other drug abusers regardless of whether the parent seeks treatment.

3. To establish a coalition comprised of persons from multi-disciplinary fields to generate and disseminate a body of knowledge and principles to define effective standards in the areas of identification, intervention and treatment for children of alcoholics and/or other drug abusers.

4. That early identification, intervention programs and support systems targeted at children of alcoholics and/or other drug abusers be implemented in every school from pre-school through college levels.

AND BE IT FURTHER RESOLVED that any and all efforts in addressing these priorities shall include all racial and cultural subgroups and children of all ages.

Adopted by the Third Annual Convention of the National Association for Children of Alcoholics in Hollywood, California on February 5, 1987.

Timmen L. Cermak, M.D., Chairman

CHARTER STATEMENT

NATIONAL ASSOCIATION FOR CHILDREN OF ALCOHOLICS

THE FOLLOWING FACTS ABOUT CHILDREN OF ALCOHOLICS (COAs) HAVE BEEN ESTABLISHED:

☐ An estimated 28 million Americans have at least one alcoholic parent.
☐ More than half of all alcoholics have an alcoholic parent.
☐ One of three families currently reports alcohol abuse by a family member.
☐ Children of alcoholics are at the highest risk of developing alcoholism themselves or marrying someone who becomes alcoholic.
☐ Medical research has shown that children born to alcoholics are at the highest risk of developing attention deficit disorders, stress-related medical problems, fetal alcohol syndrome and other alcohol-related birth defects.
☐ In up to 90% of child abuse cases, alcohol is a significant factor.
☐ Children of alcoholics are also frequently victims of incest, child neglect and other forms of violence and exploitation.
☐ COAs often adapt to the chaos and inconsistency of an alcoholic home by developing an inability to trust, an extreme need to control, excessive sense of responsibility and denial of feelings, all of which result in low self esteem, depression, isolation, guilt and difficulty maintaining satisfying relationships. These and other problems often persist throughout adulthood.
☐ Children of alcoholics are prone to experience a range of psychological difficulties including learning disabilities, anxiety, attempted and completed suicide, eating disorders and compulsive achieving.
☐ The majority of people served by Employee Assistance Programs are adult COAs.
☐ The problems of most COAs remain invisible because their coping behavior tends to be approval seeking and socially acceptable. However, a disproportionate number of those entering the juvenile justice system, courts, prisons, mental health facilities and referred to school authorities are COAs.

NACOA HAS BEEN FOUNDED TO SUPPORT AND SERVE AS A RESOURCE FOR COAs OF ALL AGES AND THOSE WHO ARE IN A POSITION TO HELP THEM

1. We believe that children of alcoholics of all ages have a common bond.
2. We define children of alcoholics as those people who have been impacted by the alcoholism or other drug dependence of a parent, or another adult filling the parental role. This results in a recognizable, diagnosable and treatable condition which can be passed from one generation to the next.
3. Despite the widespread recognition and acceptance of alcoholism as a family illness, children of alcoholics continue to be ignored, misdiagnosed and undertreated.
4. COAs deserve the understanding, information and help they need to break out of their isolation and silence.
5. The numbers of COAs and the severity of emotional, physical and spiritual problems that can be caused by parental alcoholism are compelling reasons for increasing and improving services.
6. The problems of COAs cannot be dealt with simply within individual families or the alcoholism field alone. They should be the concern of the entire community.
7. Young, adolescent and adult COAs have a right to specific remedial and preventive services, whether or not the alcoholic parent or the rest of the family seeks help.
8. As a national association, we will direct our efforts to meet the special needs of all ethnic minorities and other underserved populations.
9. The traditional mental health approach is not sufficient for COAs when it fails to recognize and treat the specificity of their condition.
10. We recognize the healing value of participation in self-help groups for those affected by alcoholism.
11. We recognize that the abuse of other drugs by a parent and other addictive behaviors which create family dysfunction can have a serious impact on children similar to that seen in COAs. The effects of these family dysfunctions are often passed from one generation to the next.
12. This association was founded on a spirit of unity, compassion, and deep concern for all those affected by alcoholism.

THE NATIONAL ASSOCIATION FOR CHILDREN OF ALCOHOLICS HAS TWELVE GOALS:

1. To increase public and professional awareness, understanding and recognition of the needs of COAs of all ages.
2. To advocate policies and accessible services addressing the unique problems arising from being the child of an alcoholic, particularly in the area of prevention.
3. To protect the rights of children to live in a safe and healthy environment.
4. To involve the entire community, especially schools, business and industry, human services, mental health, medical, religious and law enforcement professions.
5. To help existing alcoholism programs initiate primary and comprehensive services for COAs staffed by professionals specifically trained to meet the needs of COAs.
6. To support school-based programs which acknowledge and address the problems of COAs.
7. To create a network which will promote the exchange of information and resources.
8. To encourage clinical and biomedical research related to COA issues.
9. To advocate funding from public and private sources.
10. To encourage training for professionals in issues related to COAs.
11. To develop professional guidelines for those who work with COAs.
12. To offer support to professionals who are themselves COAs.

NACoA, 31706 Coast Highway, Suite 201, South Laguna, CA 92677-3044 (714) 499-3889

Senator **Dodd**. Frank, we welcome you. I guess you were the other voice on the radio program last evening as well. We thank you for being here with us today and we are delighted to receive your testimony.

Mr. **Rothgeb**. Thank you very much, Senator, and I would like to thank you for your patience. I have been very impressed by your knowledge and your questions concerning this issue. It is obvious that you have done your homework.

I come to you today not as a stockbroker certainly, and that pleases my employers—

[Laughter.]

Senator **Dodd**. We have some other committee rooms that you can testify in if you have some inside information. I am sure there are people here—

[Laughter.]

Mr. **Rothgeb**. I do not know a thing.

[Laughter.]

I also want to thank you, because I guess what I really want to acknowledge is that you were really supportive of me when you said some of the best talks that you have given have been without prepared testimony, because being a juvenile delinquent I did not do my homework, so I am just going to speak to you not from prepared notes as much as from my heart. And I want to thank you and the Children of Alcoholics Foundation and the National Council on Alcoholism for the awareness that you have started to create today.

I speak to you today as a product of an alcoholic home, as a product of the juvenile justice system, as a teenage runaway, as a victim of sexual, emotional and physical abuse. I want to talk to you a little bit about the defenses that Cathleen mentioned, the defenses that I learned to survive my alcoholic home and the defenses that I have developed to get by in the world today. They are quite different probably than Cathleen's defenses.

My home as a child was very much like my experience in Vietnam later in my life. When I say that people furrow their eyebrows a little bit and they seemed perplexed. When I got off the plane in Vietnam what I felt was tension everywhere. What I saw was expressed and unexpressed anger everywhere. You never knew when there was going to be an explosion, and what I learned to do was maintain a constant vigilance. In fact, Vietnam scared me less than my home. By the time I had gotten to Vietnam, I had developed my defenses.

How I became a juvenile delinquent was I expressed my anger when I was 8 years old by assaulting other students in the school system, and what the system did was put me into a boxing ring and say express your anger, there is a good place to do it, so I beat up children and got applause for it.

I became a juvenile delinquent. I guess the most significant thing I can remember is running away from home and it took me years to remember that the reason I ran away from home was because the two choices I had were to run away or to kill my father.

I lived on the streets and I became a person who survived any way I could. I survived—I am not a case study, I am a product of the system. I survived by selling everything I could, including my body, by stealing when I could, by lieing. I forgot what the truth was by the time I picked up my first drink, and I certainly did not want to drink because I had seen the insanity of alcoholism and I swore it would never happen to me.

So I learned on the street to be tough, to act tough. I swore at one point that nothing would ever hurt me again, and I survived those experiences. I became addicted to alcohol and drugs at an early age, and I got through the school system. I was thrown out for a year from the Maryland State School System. They labeled me an uncontrollable child.

Fortunately, I went back to school and graduated and went to Vietnam. I became further addicted to alcohol and, thank God, there was a little glimmer of light inside of me and so there came a point in my life where I decided that I wanted to live more than I wanted to die and I reached out for help and I got help.

Because of the awareness that the National Council on Alcoholism created, and the fellowship of Alcoholics Anonymous created, I was able to reach out for help and because I said a prayer which was basically "help me." I got help.

I then started developing different defenses. I have not found it necessary to take a drink or a drug for seven and a half years now. So I went from being what we call the scapegoat kid, the juvenile delinquent, the acting out child who acted tough, like nobody could hurt me, to become the hero that Cathleen mentioned.

I became part of the sales force of New York life, I was a part of the top ten per cent in the Nation. I bought a restaurant when I was 23 years old as a result of working my way up. I became a stock broker because I took self studies and correspondence courses, and I kept trying to prove that I did not hurt. I think there was something going on unconsciously where if I could just achieve something, if I could just become like you, then I would feel okay inside. None of that stuff worked.

Thank God for the National Association for Children of Alcoholics and thank God for Migs Woodside and her programs, because they validated my experience and they told me that there was something still wrong that could lead me to suicide, and I began my recovery three and a half years ago and, I want to tell you something, my life has gotten better and better and better as a result of that.

I am involved with helping teenagers and I cried when Phil Diaz talked. I have heard a lot about education today. I have heard in my studies and my travels in the juvenile justice, the government agencies and stuff, a lot about scare the children, scare the adolescents, show them what they will become, help them acknowledge that they are the high risk youth and educate them.

As a juvenile delinquent, what I would have liked was someone to say to me your experience was tragic, to teach me how to love. Programs like Ellen Morehouse and Rochelle Lerner and Rosemary Tisch are doing that for the young children their teaching them that they are okay and showing them the alternatives when "they just say no," I would have liked that a lot.

What I got unfortunately still exists in the runaway shelter program. I got a lot of, "Well, your mother and father really do love you, you ought to go home, I'm sure they're scared." You know, by the time I had survived my early childhood, 5 to 12, I certainly was not afraid of the future, you know. I mean I believed nothing could hurt me at 13 or 14 years old any more, so I do not believe adolescents today can be scared into changing. I think they need to be loved into changing.

You know, you mentioned the juvenile justice system and the disproportionate number of youths entering that system. As a member of the Washington Area Association for Children of Alcoholism and Other Addictions, I would like to make a recommendation to you on behalf of all the members that are here today, and that recommendation would be that the Juvenile Delinquency Prevention Act of 1974 be amended so that you could identify and give special emphasis to the high risk youth, so that some of these programs could be instituted that would help these children.

I would also like to recommend to you that this runaway shelter program, that the people that are there, the staff be trained to identify and to treat children of alcoholics.

In closing, I would like to say that this is not about blaming our parents. I consider my parents very much a victim of this disease. It goes back generations. And the reason that it is so hard to get the parents into treatment as far as I am concerned, my opinion only, is they built their own defenses.

My family looked good on the outside, possibly as good as yours. My mother was active in politics. My father ran a sports coliseum. Nothing was wrong on paper. Unfortunately, they were both children of alcoholics and it does not get any better, it only gets worse.

So I would like to thank you for listening to us today, and I hope that something does come out of these hearings.

Senator DODD. Thank you very much. You have been very compelling.

And our last witness, Beverly Jones. Beverly, we thank you for coming today, and congratulations on your new position.

Ms. JONES. Thank you. I want to thank you for this opportunity to address an issue that I think has increasing importance and significance to those of us who are administrators and managers, and that is the extent to which an adult who has had an alcoholic or and abusive or a neglectful parent is able to deliver effective services to families in trouble, in particular families where abuse and neglect have occurred.

This becomes particularly acute when we consider the fact that a substantial number of families that we serve in the Child Protection Service delivery system have substance abuse as a theme.

What unresolved issues do staff bring to the job when they are the product of an alcoholic or abuse or neglectful childhood environment? How do we as managers identify staff or assist staff in this area? When can this experience be effective or helpful in their work? These are some of the questions that I believe need to be addressed and answered, and probably those of us who have been administrators and managers have ignored them far too long and I think we need to put it in a certain context.

Maryland, like most other States, has over the past several years seen a dramatic and sustained escalation of reports of child maltreatment. There is nothing in the data to suggest that the numbers of reports of abuse and neglect are going to decline.

You couple that with the suggestion that or the research that indicates that one out of four females and 1 out of ten males will be sexually abused before they reach the age of 18. Moreover, we know that substance abuse is almost always a theme in our caseload where children are at the greatest risk of physical and/or emotional harm. What do these statistics suggest?

It appears to be that many of our children have grown and continue to grow up in chaotic, disorganized and unhealthy environments. As such, the pool of potential candidates from which we recruit staff mirror this phenomena. From my perspective, we are seeing a greater number of families where violence, substance abuse, and child maltreatment are norms of behavior.

While I cannot provide you with an exact number, I am going to give you an educated guess that a good number of the staff who in the child protective services program in Maryland, about 25 percent of them come from families that I just described to you. How do I know this as a manager or how do I get this information? That is a very difficult question and I do not know that I have the answer to that.

But I think we need to think about children who come from such environments come with feelings of anger, depression, low self-esteem, rage, shame, guilt, and without appropriate intervention these emotions do not disappear but, rather, they fester and they build.

As staff working in the area of child protection, you are faced with families that have the same family themes that you had as a child, uneasiness and discomfort begin to appear, and I think are manifested in two ways. Both are extreme and nonconstructive.

The first scenario goes as staff members begin to ask that certain cases not be assigned to them. The casework is characterized by punitive, hostile, and angry approach, the need to punish, to get back becomes paramount in their work. The rescue fantasy sets in and the need to begin to ask that children be removed from these bad parents take over.

The second response seems to be a complete rejected of what is going on in the family you have been assigned to work with. The employee refuses to identify the family situation for what it is. To call this family abusive or neglectful or alcoholic is to identify one's own family as such, and the need to continue the denial is paramount. To accept the reality of one's own family situation triggers all those old feelings which one has diligently fought to keep dormant.

I think when you think about that and you couple that with the unrelenting pressure and daily stress of making decisions that literally could have life or death importance, no wonder we hear about burnout and high turnover rates in our program.

As a manager, the question is how do we intervene. Occasionally an employee will come voluntarily and ask for your assistance. More often than not, employees work diligently to continue the family silence. Even when asked in a private individual supervisory conference, an employee will deny vehemently your observations.

The challenge before us is how do we create an environment which promotes openness and honesty as well as guarantees the person confidentiality. There is not a simple answer when a crucial job remains to be done, and that is protection of children. Do you relief staff of certain duties while they attempt to resolve their own personal issues. I wish I could give an unequivocal yes, but unfortunately oftentimes we do not have that luxury. Current staffing levels do not permit that kind of strategy frequently.

I do want to say that in Maryland we have been able to develop a small pilot program with a private provider to conduct a therapy group for adults who were sexually abused as children and are now employed as child protective service staff and employees have been guaranteed confidentiality. It will be important for us to follow that program and adapt it to other areas of concern.

I do want to say that there are staff who are children of alcoholics and who work extremely well with our families, and I try to think about what is the difference between that staff and the staff that I described to you earlier, and I think, as I think about it, that somehow, some way in their life intervention happened, appropriate intervention happened and effective intervention happened, and they therefore come to the job with a deeper sense of empathy, sensitivity, and a broader knowledge base.

In addition, they are able to be directive, confrontive when necessary, and well focused in their work. The question becomes what can we do about this issue, and I think we need to understand that it is a complex issue and one that is not easily fixed.

We need first to understand the environment in which this occurs. We have families that are under stress, that the whole nature of what we call family is changing, and that parenting under the best of circumstances is difficult and demanding.

It appears to me that the long-term solution is to develop programs that strengthen families, restore stability and hopefully prevent dysfunctioning from occurring in the first place. Children belong with their families and we have to find a way to ameliorate the conditions that lead to dysfunction and disintegration.

In terms of what do we do now, as employers we need to be trained in how to interview effectively so that identification of staff with what I call personal baggage is done immediately. We need to have specialized programs for current staff who are presently struggling with this issue. Training programs must be developed and designed for these staff, values clarification, self awareness, as well as techniques for handling the stress and pressure under which they are currently working gets addressed.

I think the Federal Government has the opportunity to be a leader in this field and that the rest of the States will follow.

In conclusion, I say this topic is worthy of careful discussion and intervention. Work with abusive, neglectful, alcoholic and substance abusing families is a demanding job. It is one that requires competence and professionalism. Successful intervention of families is also dependent upon the extent to which staff resolve their own issues around their own personal victimization.

I think the Committee has taken a great first step in this process and I thank you for inviting me to participate. And before I finish, I was asked to bring someone with me—and I did—David Ladd, who is director of a program in a local jurisdiction. I kind of gave you a perspective and, if you do not mind, I would like for him to give you his thoughts.

Thank you.

[The prepared statement of Ms. Jones follows:]

STATEMENT OF
BEVERLY W. JONES
PROGRAM MANAGER
CHILD PROTECTIVE SERVICES
DEPARTMENT OF HUMAN RESOURCES
STATE OF MARYLAND

May 12, 1987

Good morning. I am Beverly Jones, Program Manager for Child Protective Services in Maryland. I am responsible for the administration of services to abused and neglected children and their families.

I want to thank the Committee for this opportunity to address an issue of increasing importance and significance to administrators and managers -- the extent to which an adult who has had an alcoholic parent or parents is able to deliver effective service to abusive and/or neglectful families. This becomes particularly acute when we consider the fact that a substantial number of protective services families (approximately 35%) have substance abuse as a familial theme. What unresolved issues do staff bring to the job when they are products of an alcoholic or abusive or neglectful childhood environment? How do we, as managers, identify staff or assist staff in this area? When can this experience be effective or helpful in their work? These are some of the questions that need to be addressed and answered. I, therefore, commend this Committee for convening this hearing and for its efforts to highlight this matter.

Maryland,like most states, has seen a dramatic and sustained escalation in reports of child maltreatment. Over the past eighteen months, child abuse and neglect reports have increased by 27%, and our analysis of the data indicates that the rate of growth is likely to be even greater in the future. The professional literature indicates that one out of four females and one out of ten males will be sexually abused before they reach the age of eighteen. Moreover, we know that substance abuse is almost always a dominant theme in our caseload where children are at the greatest risk of physical and/or emotional harm. What do these statistics suggest?

It appears to me that many of our children have grown and continue to grow up in chaotic, disorganized and unhealthy environments. As such, the pool of potential candidates from which we recruit staff mirror this phenomenon. From my perspective, we are seeing a greater number of families where violence, substance abuse and child maltreatment are norms of behavior.

While I can not provide you with exact numbers, a good number of staff (an educated guess is 25%) who work in the Child Protective Services Program in Maryland, come from the families that I just described to you. How do I or any manager obtain this information?

Anger, depression, low self-esteem, rage, shame, and guilt are some of the feelings that can result from a childhood where a parent(s) was abusive or neglectful or alcoholic. Without appropriate intervention, these emotions do not disappear, but rather, they fester and slowly build. As staff, working in the area of child protection, they are suddenly faced with families that have familiar family themes. Uneasiness and discomfort begin to appear and are manifested in one of two ways. Both are extreme and destructive. The first is as follows: Staff begin to ask that certain types of cases not be assigned to them. Casework is characterized by a punitive, hostile and angry approach. The need to punish is paramount. The "rescue fantasy" sets in; all children must be removed from these "bad" parents. The second response seems to be a complete rejection of the current family dynamics. The employee refuses to identify the familial situation for what it is. To call this family, which has all the dynamics of one's own family, abusive or neglectful or alcoholic is to identify one's own family as the same. The significance of what this may mean is too powerful for the employee to handle. Denial becomes a defense for the individual's own protection. To accept the reality of one's own family situation triggers all those emotions which one has diligently fought to keep dormant.

Coupled with these dynamics, are the unrelenting pressure and daily stress of making decisions that literally could have life or death importance. No wonder, we hear about burnout and high turnover ratios in the Child Protective Services Program. As a manager, the challenge is how do we intervene?

Occasionally, an employee will come forth voluntarily and ask for your assistance. More often than not, employees work diligently to keep this family secret. Even when asked in an individual supervisory conference, an employee will vehemently deny your observations. How do we create an atmosphere which promotes openness and honesty as well as guarantees confidentiality? There is not a simple answer when a crucial job remains to be done -- namely, the protection of children. Do you relieve staff of certain duties while they attempt to resolve their own personal issues? I wish that I could give an unequivical yes but unfortunately, we frequently do not have that luxury. Current staffing levels do not permit this strategy. However, in Maryland, we have been able to establish a small pilot program with a private provider to conduct a therapy group for adults who were sexually abused as children and now are employed as child protective services staff. Employees, who are participating in this program, have been guaranteed confidentiality.

I do need to point out that there are staff, who have had these childhood experiences, and who work extremely well with families. These staff differ from the others that I described to you in that intervention was obtained and used well. They, therefore, come to the job with empathy, sensitivity, and a broader knowledge base. They are able to be directive, confrontive, when necessary, and well-focused.

What can we do? What all of us need to understand is how complex this issue is and what it wil take to "fix" it.

We need first to understand the environment in which child maltreatment occurs. We have families that are under stress, that the nature of the "family" is changing, and that parenting remains a difficult and demanding job. It appears to me that the long-term solution is to develop programs that strengthen families, restore stability and hopefully, prevent dysfunctionning from occurring. Children belong with their families and we have to find ways to ameliorate the conditions that lead to dysfunction and disintegration.

What do we do now? As employers, we need to be trained in how to interview effectively so that the identification of staff with what I call "excess personal baggage" is done immediately. In addition, we need to develop specialized programs for our current staff who are presently struggling with this issue. Lastly, training programs must be developed and designed for these staff. Such issues as values clarification and self-awareness would be addressed as well as techniques for handling the stress and pressures under which they are currently working.

The federal government has the opportunity to be a leader in this field. The provision of monies through the discretionary funds is essential. States would have the opportunity to evaluate these model programs and adapt them to the needs of their particuar state.

In conclusion, I say that this topic is worthy of careful discussion and interventiion. Work with abusive/neglectful/alcoholic families is a demanding job. It is one that requires competence and professionalism. Successful intervention with families is also dependent upon the extent to which we help staff resolve issues around their own personal victimization. This Committee has taken the initial step in this process and I thank you for inviting me to participate.

Thank you.

STATEMENT OF DAVID LADD, DIVISION CHIEF, CHILD PROTECTIVE SERVICES, ANNE ARUNDEL COUNTY, MD

Mr. LADD. Thank you.

Senator DODD. I apologize and ask you to be brief because we are going to lose the room here. Why not reintroduce yourself.

Mr. LADD. My name is David Ladd and I am Division Chief, Child Protective Services, Anne Arundel County, Maryland.

I think the only thing I can add is maybe an elaboration on something that Phil Diaz says, that juvenile services and the protective service staff are the treatment sources for children of alcoholics and I think we need to think about that. I think we really need to take a look at what that means from my perspective as a protective service worker.

We are sending staff out with a power to remove children sending them into a person's home, that family that is in this court is aware of the power that that worker carries in his back pocket, and when you are messing with a person's children you get into some really very basic emotions, very hostile situations, a lot of family violence.

One of my staff was kidnapped by a parent in the past year, a year ago. We are asking them to deal with a progression on a day by day basis, month by month of a series of children that they see that are abused, sexually molested, that are neglected, so it is no wonder that we have burnout situation developing, staff turnover being very high, and if you couple that natural pressure of doing that type of work with a background where they themselves were abused or they themselves came from a family where alcohol was a factor in their family life, then the pressures even double and their difficulty in dealing with this type of situation and the effect on the staff is there.

You do not see it so much as staff failing to come into work because they are drunk, but just basically a pullback from dealing with the situations that are presenting themselves and what happens then is there are some talented people that have capabilities for this field and they leave.

What I think we need to do is to look at the pressure that is put on a staff and, as Beverly Jones says, come up with a way of dealing with that and identifying those individuals. I myself had a member of our division which we had to remove from protective services because that person was just not able to handle that, given the background that they have.

So it is important I think if we are going to be the ones that are going to be working with the children, we have to be able to deal with the problems that we bring to the job if we are going to be able to do a good job with the kids we are going to deal with. I think quite often that is forgotten about.

The staff in this field often see themselves and the system sees them as iron men that are sent out to handle the problems and have no problems themselves. We have an employee assistance program in Maryland where if an employee is not functioning well can be referred to it and obtain counselling. The problem then is the fact that there is some stigma attached to that, the fact that they are not performing well.

We need to develop an employee assistance program I think across the country that are not stigmatized, that are designed to come at the employee from a more positive standpoint.

Thank you.

Senator DODD. Thank you very much for being here.

I thank all of you for being here today and I particularly want to thank you, Cathleen and Frank, and I am sure the other witnesses will appreciate why. It comes across clearly to me the sense of joy that you have because you are able to do something. I cannot tell you how important it is. I am sure you have heard this from others, but let me just add my voice to what others have said.

Senators can talk, Congressmen can talk, Ph.D.'s and doctors and protective service people can talk, and we can have artists and TV shows and everything imaginable. But we do not even remotely come close to doing as much good as people like you who have been there and can talk about it. I think that is true in many areas, but certainly no less in this one.

Senator Thurmond regretted earlier that we did not have C-Span or something, that now very wonderfully covers a lot of hearings from gavel to gavel, and I think it would have been important for them to have heard the people who work in the field as professionals. I really regret that they did not hear the two of you across the country. If I could have only had two witnesses here today, with all due respect to all the others, I would have loved to have had the two of you. It was really compelling and marvelous to hear you talk.

Again, I do not have a lot of questions for you. I happen to like Geraldo Rivera. I think he makes interesting television. He is a darn good journalist in many instances but I wish he could have talked to a few people before he did that program on runaways and it was not just say no, it was his message to runaways was not "just say no." Rather, it was "go home."

In listening to the two of you and others that I am familiar with, it strikes me that advising all runaways to go home may not be wise. Runaways as I said earlier, are in terrible situations. It is not that where they end up is necessarily better than where they have come from. But it is no worse than what they ran away from. And when you tell them to go home, you are asking them to go back to a situation that in their minds is intolerable.

So the idea of "just go home" is not always a valid issue. Frank, in your case, I think we all agree that more research on the issue of runaways would be important for the next Geraldo Rivera program. Because if it was designed to reach any of those kids that are running away, I suspect it had minimal effect except for those who maybe had gone overnight somewhere, around the corner.

Obviously, substance abuse is what I have been trying to focus on; and alcohol abuse is the one that is the most dominant, and drug abuse is a growing problem. With the baby boom generation of which I am a part, it is apparently a growing problem. It does not seem to be abating tremendously.

Do you have any comments you would like to make about that particular aspect? What you are seeing, Cathleen, in your own work? And then, Frank, what you are seeing maybe with the adolescent kids you are working with? Are you seeing more or less of it?

Ms. BROOKS. Senator Dodd, four years ago next step created a . model program in San Diego at Sharp Cabrillo hospital to treat children of alcoholics and addicts of all ages, and the thing that is most striking is that in our treatment of young and adolescent children, we find that only approximately 10 percent of the kids under the age of 18 that we are treating come from pure alcoholic homes. The vast majority of them come from alcohol and drug abusing homes.

I have supplied for the committee's review, a video cassette of a "60 Minutes" segment, aired September 28, 1987, which explores the problems experienced by children of drug abusers. The special focus is on parents who actually supply drugs to their children. In the video, you will see children in our treatment program talking about their lives and their recovery process.[1]

In terms of clinical observation, as you note, we need to do the empirical studies to find out what kinds of impacts we are finding there as opposed to in the pure alcoholic home, but in clinical observation I can assure you that everything that you have heard today about what we know about children of alcoholics can be held true for what we know about children of drug addicts. In fact, who we are really treating today, those few of us across the country who are actually treating young children of alcoholics clinically, are children of drug addiction, with alcohol being one of drugs.

The only clear difference seems to be that those children whose parents are addicted to illegal substances tend to have, interestingly enough, either a heightened or a much lowered sense of shame, and the heightened sense of shame comes from those kids who know that this is illegal and improper and that their parents are criminals, especially those kids treated whose parents are actually pushing drugs and know that that is where the family income is coming from, there is a lot of shame around that.

And then the lowered sense of shame is actually not a positive thing, it comes from kids who have been brought up without any values whatsoever, in which drug use, abuse and sale are the norm of the family, and in that case the lowered sense of shame is more than made up for in damage by the fact that these children are brought up with very false value systems.

Senator DODD. Frank?

Ms. ROTHGEB. Senator Dodd, I think I prefer to answer this question from a stockbroker's point of view. I think we are spending a whole lot of money on trying to keep illegal drugs, so to speak, out of this country and anytime you have a law of supply and demand working as well as it is in this country, you are not going to be able to keep drugs out of the country.

If you think hearing from children of alcoholics in this decade is scary, you wait until you hear the testimony of children of PCP and cocaine and the others, and that does not diminish the effect of the commercial attach to alcohol that says "it does not get any better than this". At the same time, it gets real scary when you see children from dually addicted parents, and I do. I mean I go once a week and I listen to these children and I hear them say things like, "My family wouldn't beat me up if I wasn't bad," and they just do not understand that they are not the problem, and it is the message that I have heard today, and the message that I have heard today is that somehow we have to carry the message to these children that they are okay.

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[1] Accompanying this testimony is a video cassette of a "60 Minutes" segment about children of drug abusers.

Senator DODD. It is presumptuous of me sitting here, but should the title of the organization be changed?

Ms. BROOKS. That is a very interesting point. When we started four years ago to focus was on children of alcoholics, and we made the determination at that time that in order to really reap the benefits of this heightened awareness we needed to stay focused on "Children of Alcoholics."

Frank Rothgeb represents one of our new State chapters. We have 12 State chapters at the present time. Most of our State chapters are including "other addictions" in their names and I am fairly sure that as the rational organization goes on in its history, the national board too will look at that. Our charter statement currently clearly states that we are looking at the same syndrome with children of other addictions.

Senator DODD. Joe Califano mentioned the idea of that National Center on Addiction, which I think is a very good idea.

Frank, I saw a lot of heads nodding in the audience earlier when you talked about scaring children with the just-say-no programs. You then said what the children really need is love. I certainly would not disagree with you on that, but you do not get love from a student counsellor or from a principal or an assistant principal or a child protective service worker. A child senses that unique, loving relationship from only a handful of people. Who fills the void on that?

I mean I do not disagree with the bottom line, but how do you get there? Who provides it?

Mr. ROTHGEB. That is a very good question, Senator Dodd. I think Phil Diaz made the point though that you cannot get love from an empty well, either. I appreciate the Federal Government's stance on strengthening the family unit and I understand it, but if the family unit has been dysfunctional for generations, you are not going to change it overnight.

The programs, as I see it, can provide love. The programs that are created through student assistance programs, through elementary school projects such as the National Association for Children of Alcoholics is trying to start. I agree with you 100 percent, or whoever said it earlier, there is too much pressure put on teachers as such, but if you can somehow have the student self-identify and the student recognize when the child is having the problems, and you can get him to a workshop—there are enough community volunteers to finish the job, believe me.

In our own organization, we sent out 500 fliers and we got I50 people to attend our opening organizational meeting for children of alcoholics. Now, I know that you political people would love to have that kind of mail response rate. I mean, 50 percent suggests that there are people around familiar with the problem who are willing to help. We just need to unify.

I think Mr. Califano's idea about the council, where all organizations can get together and take definite small steps to solving this problem is an excellent one.

Senator DODD. Not to answer my own question, but one of the things I thought you might suggest and something that Phil Diaz brought up are these children themselves—he told that story about three kids. I forget how it worked, but in the end the young girl said, "I'm a Spic and I love you." Maybe in the absence of aunts and uncles and parents and so forth, maybe just that common denominator there of children getting together may be part of it. I do not know whether it is or not.

Mr. ROTHGEB. Exactly. I think that is a wonderful idea.

Ms. BROOKS. What we have found is that in self-help groups such as Alateen, Al-Anon, and the Adult children of Alcoholics Movement, which is growing at an astonishing rate, as well as in clinical settings such as the one I have been describing to you that we run in San Diego, and school based programs, is that the kids go through a three-step recovery process.

The first step for kids and adults is recognizing that they do feel alone. You see, one of the defense mechanisms is "I do not need anybody, there is no one to love me and I do not need anyone." So the first step is to say you *do* need somebody.

The second step is for the "helpers" to say we are not your family and we cannot ever make believe that we are as good as having a mom and dad who are there to love you, but we can show you some things about how to take care of yourself. I think that is really what we have to start teaching kids as well as adults.

Then the third stage is when the kids or adults begin to accept that personal responsibility for their own recovery and can do it within a safe environment of a group or whatever. What Phil Oliver Diaz described about the group that he was working with is something I see every week with the kids I work with—that bonding to the group and that sense of trust that they feel with others who have traveled the same path.

Senator DODD. As we get older we are far more reluctant to share things. I find children are the best audience. I do not hold town meetings. I stopped holding town meetings years ago, although it was a popular vehicle. I do high school forums now and I find the high school students, juniors and seniors particularly, are open. They listen. They will express their views honestly to you and they will listen to an answer.

I think as adults, we know the answers we want to hear. If you do not say the right answer, we do not like it. We already have the answer in our head and children are far more receptive—the young adults, I should say in that case.

Frank, who else is in this kind of professional crowd with you? The rest of us are kind of interested in hearing what a stockbroker has to say, but how does a stockbroker relate to a 12-year-old Frank Rothgeb? Imagine yourself now at 12 and you walk in, you are a stockbroker, you make no sense to me whatsoever.

Mr. ROTHGEB. No comment, Senator. [Laughter.]

I really do not understand the question.

Senator DODD. Well, who are some of the other people who are working with you as volunteers? I am just trying to imagine what you would have been like if a stockbroker had walked in to talk to you when you were 12 and you were at that sort of Zenith, if you will, of your acting out.

Mr. **Rothgeb**. Sure, I understand the question. I thank you. You know, we all know that alcoholism is an equal opportunity destroyer and it crosses all barriers. Volunteers in our organization, the same statement is true, they relate to these children. We do not relate to them as stockbrokers, although, you know, it is kind of funny.

I went into one group and I wanted to share my deepest experience and connect on an emotional level and they wanted to talk about my Gucci shoes, to them that was important.

You know, we have people that are social workers, we have people that are nurses, doctors, psychiatrists, we have people that are businessmen, and they all want to help. When they go into these places and they do these programs for the adolescents and the young children, they relate to them from their childhood. In fact, a lot of adults, this is such a new recovery process that inside we all have lessons to learn, and our childhood for most of us has been lost. When we go in there and we work with six-year-olds, they are the teachers, you know. We do our therapy with them and we love them and we get them together, but then we watch them, you know, because they teach us how to act, how to have fun.

Senator **Dodd**. Beverly, you are very sensitive with some of the recommendations you made. I am particularly curious about the one where you try to be more sensitive in terms of hiring the person who comes in with what you describe as baggage. But I have to believe that some of these people, prospective workers, are going to be pretty defensive and have been pretty good at hiding things over the years. The last thing anyone wants to do on a job interview is to say, by the way, I am a high risk employee. That high risk person knows that there are 10 other people that you are interviewing for that job. How do you keep from saying, look, I have enough problems as it is. What I need is someone who can get the job done. I do not want someone who is an additional client. How do you get around that problem? What abut job discrimination on the basis of that?

Ms. **Jones**. Well, I think that is——

Senator **Dodd**. Even with organizations that work in the area and have a degree of sensitivity, they may not want to hire that worker.

Ms. **Jones**. I think that is what makes it difficult. And I think there are people who personally who, I do not know, end up having me tell things I have never told anybody else or would think about telling anybody in an interview, and I have to stop and think, I think there are ways to do that. You certainly do not ask what I call stupid questions. You do not ask somebody were you abused as a child in a job interview, they are going to tell you no, that is not the way to get to the information, but I think you can.

The whole question is just because you were does not mean you cannot do the job either, but that is—I do not know the answer to that and that is something we struggle with all the time, that you have—the fact of the matter is you are going to have people on your staff, whether you are able to get that information up front or not, the question then is if you have them on your staff then what do you have to have in place to help support them so they will be able to do the job, because it can be a very powerful and effective tool, and some of our best staff come from these environments, have resolved it for themselves and move on and do wonders with families. That should not be the sole criteria for screening someone out from the job.

Senator DODD. If I listen to what Cathleen Brooks has to say about adult children of alcoholics, many want to achieve and to prove that they can reach whatever goals they set. Many want to get involved in helping others. So is it fair to assume that an awful lot of people that are coming to your door looking for jobs are people who have been affected by parental alcoholism? If I listened to you correctly, I think your point was that the desire to rescue all other children from alcoholic homes is in itself is a manifestation of a problem. Such workers are just determiend to get in, feeling no one solved it for me so I am going to solve it for them. But your point is that such workes may not be in the best position psychologically to do it.

Ms. JONES. Right. I think there are more questions than we have answers at this point in time, because as managers we put our head in the sand and pretend that we have super people working for us who came from I do not know where, have no—I mean we all bring baggage to a job, when you start talking about working with families. All of us have had experiences with that and we have feelings about that, but I think we have ignored it and just pretend that our people have just got to create it, okay, now go do your thing, they did not come form families that may have had similar problems like that and we need to begin to identify the questions and then how do we get some of those answers.

Senator DODD. Do you have any sessions, in the evening or Saturday, when you invite the people that work with you to get together, not to talk about the clients but talk about each other?

Ms. JONES. Yes, and that is where we get information and people tell you things. Staff on their own get together in their own kind of informal support systems. I mean they not talk to a supervisor or an administrator, but they certainly talk to each other and go off and do that.

We have had support groups for our staff not to talk about the work but just to talk about themselves, and that information is confidential, what they discuss stays in that group and we do not know about it, and I hope we do a lot more than that. We just put our head in the sand too long.

Senator DODD. Thank you very much.

Mr. ROTHGEB. Senator Dodd, I would like to respond to that question briefly, because a little fear came up inside of me that we might be screening people out of jobs because they are COAs. In fact, their worst part is also their best part. Because they are COAs, yes, they are subject to some of the things that Beverly talked about, but also because they are COAs they can share their experience with people who are entering the system.

In fact, Anne Arundel County and the State of Maryland is working with the Washington Area Association to do training and a workshop for most of their system, and my experience with that is that the COAs step out of the woodwork and help more often than not. I just wanted to make that point.

Senator DODD. That is why I raised the question, because it struck me as well when you said it. I was concerned about the screening process.

Again, I thank all four of you for being here. It has been tremendously helpful to me and it is not the end of a hearing process but the beginning of one. I do not have any earth shattering ideas for you at this particular juncture on how we eradicate this problem. We are developing some awareness and understanding that it is a generational problem. It can begin during pregnancy and continue right up until a person is well into adulthood. I think that it is a major step forward to understand that the effects of parental alcoholism can run the entire spectrum of a person's life. I think we can now fosuc on new ways to encourage treatment, counselling, and public awareness through advertising and the educational system to begin to make some inroads.

I have been here for 13 years, in the House and the Senate, and I have only just recently become a Chairman, now that I am in the majority. I have attended a lot of very good hearings over the past 13 years and I want to tell you all this morning, this is as good a crowd as I have ever seen testify before the Senate. I thank you all very much.

My thanks to all of you for coming.

This hearing is adjourned.

[Whereupon, at 1:32 p.m., the subcommittee was adjourned.]

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